Supreme Court, U.S.
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No.

In The

Supreme Court of the United States

October Term, 1997

UNIVERSITY HEALTH SERVICES, INC.,

Petitioner,

vs.

DONNA E. SHALALA, Secretary of Health and Human Services,

Respondent.

On Petition for Writ of Certiorari to the United States Court of Appeals for the Eleventh Circuit

PETITION FOR WRIT OF CERTIORARI

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QUESTIONS PRESENTED

1. The appropriate interpretation and application of the legislative moratorium contained in the Omnibus Budget Reconciliation Act of 1987, § 4008(c), as amended. Specifically, what circumstances trigger application of the moratorium preventing the Secretary from effecting a change or more stringent application of Medicare reimbursement policy.

2. Whether the fiscal intermediaries' prior acceptances, through reimbursement, of University Hospital's Medicare bad debt collection policy, specifically its policy of not sending Medicare accounts to a collection agency following the hospital's intensive collection process, constitute acceptances triggering application of the OBRA moratorium and precluding the Secretary from denying reimbursement for the hospital's Medicare bad debt expense incurred during fiscal year 1986.

PARTIES TO THE PROCEEDING

All parties to this proceeding are listed in the caption of the case. University Health, Inc., a non-profit Georgia corporation based in Augusta, Georgia is the parent company of University Health Services, Inc. University Health Services, Inc., the petitioner in this case, operates University Hospital in Augusta, Georgia.

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Petitioner, University Health Services, Inc., d/b/a University Hospital, respectfully petitions this Court for a writ of certiorari for review of the judgment and opinion of the United States Court of Appeals for the Eleventh Circuit, entered in the above-styled proceeding on August 28, 1997.

OPINIONS BELOW

The opinion of the United States Court of Appeals for the Eleventh Circuit is reported at 120 F.3d 1145 (11th Cir. 1997) and is reprinted in the attached Appendix. (App. at 1a).

The order of the United States District Court for the Southern District of Georgia, 1995 WL 842005 (S.D. Ga. Sept. 28, 1995) (Bowen, D.J.) is not reported in the Federal Supplement. The district court's order is reprinted in the attached Appendix. (App. at 20a). The decision of the Health Care Financing Administration dated September 8, 1993 is reprinted in the Appendix. (App. at 41a). Similarly, the decision of the Department of Health and Human Services' Provider Reimbursement Review Board, dated July 9, 1993, is also included in the Appendix. (App. at 60a).

STATEMENT OF JURISDICTION

Invoking federal jurisdiction under 42 U.S.C. § 1395oo(f), petitioner appealed the final decision of the Secretary of Health and Human Services. The district court entered a final judgment on September 29, 1995, granting petitioner's motion for summary judgment. (App. at 40a).

The Secretary of Health and Human Services subsequently filed a notice of appeal with the Eleventh Circuit which had jurisdiction under 28 U.S.C. § 1291. On August 28, 1997, the Eleventh Circuit entered an order reversing the district court's opinion. (App. at 1a). Petitioner timely filed a petition for rehearing

which was denied by the Eleventh Circuit on November 26, 1997. (App. at 82a).

This Court has jurisdiction to review the judgment of the Eleventh Circuit pursuant to 28 U.S.C. § 1254(1).

STATUTORY PROVISION INVOLVED

> In making payments to hospitals under title XVIII of the Social Security Act [this subchapter], the Secretary of Health and Human Services shall not make any change in the policy in effect on August 1, 1987, with respect to payment under title XVIII of the Social Security Act [this subchapter] to providers of service for reasonable costs relating to unrecovered costs associated with unpaid deductible and coinsurance amounts incurred under such title (including criteria for what constitutes a reasonable collection effort, including criteria for indigency determination procedures, for record keeping, and for determining whether to refer a claim to an external collection agency).
>
> The Secretary may not require a hospital to change its bad debt collection policy if a fiscal intermediary, in accordance with the rules in effect as of August 1, 1987, with respect to criteria for indigency determination procedures, record keeping, and determining whether to refer a claim to an external collection agency, has accepted such policy before that date, and the Secretary may not collect from the hospital on the basis of an expectation of a change in the hospital's collection policy.

Omnibus Budget Reconciliation Act ("OBRA") of 1987, Pub. L. No. 100-203, § 4008(c), as amended by Technical and Miscellaneous Revenue Act of 1988, § 8402 and OBRA of 1989, § 6023, *reprinted in* 42 U.S.C. § 1395f note (1992).

STATEMENT OF THE CASE

Petitioner, University Health Services, Inc. ("University") operates an acute care, non-profit, teaching hospital located in Augusta, Georgia. Through this lawsuit University seeks reimbursement under the Medicare program for Medicare bad debts incurred during fiscal year 1986 in the amount of $524,807. University's Medicare bad debts consist of deductible and co-insurance amounts for treatment rendered by University which remain unpaid by Medicare patients. Medicare will reimburse hospitals for the costs related to these bad debts if they meet certain regulatory criteria including the provider's demonstration that it used "reasonable collection efforts" to obtain payment from Medicare patients. *See* 42 C.F.R. § 413.80(e). The program's reimbursement of Medicare bad debts is in furtherance of Congress' prohibition against shifting to non-Medicare patients the necessary, direct or indirect cost of providing services to Medicare beneficiaries. 42 U.S.C. § 1395x(v)(1)(A); *see also St. John's Hickey Memorial Hospital v. Califano*, 599 F.2d 803, 812 (7th Cir. 1979).

During a 1989 audit of University's cost report covering fiscal year 1986, Blue Cross and Blue Shield, the fiscal Intermediary who is given authority by Medicare regulations to conduct such audits on behalf of the Secretary, disallowed the hospital's claim for Medicare bad debt reimbursement. The uncontroverted evidence establishes that University has used the same collection practices for many years and until the 1989 audit, reimbursement was repeatedly and consistently made. For each of the years prior to 1986, University's Medicare cost reports were audited by the Intermediary but no question was ever raised regarding the reasonableness of the hospital's Medicare bad debt collection efforts. Because it was not until the Intermediary's 1989 review of University's 1986 cost report that the hospital became aware of the Secretary's opposition to its collection policies, University

employed the same collection efforts for years 1987 and 1988. The Secretary has subsequently denied reimbursement for Medicare bad debts incurred by University during these years in the amounts of $445,828 and $563,645 respectively. These amounts constitute approximately 99% of the unpaid Medicare deductibles and co-payments for these years.

The evidentiary record in this case was developed during a hearing held before the Provider Reimbursement Review Board ("PRRB"), a four-member administrative board appointed by the Secretary and having knowledge in the field of cost reimbursement. *See* 42 C.F.R. § 405.1845. During the PRRB hearing, the Secretary's Intermediary acknowledged that University's 120-day collection process for its Medicare accounts was a genuine, not just token, collection effort which treated both Medicare and non-Medicare accounts identically. In fact, the Intermediary conceded that if University had terminated its collection efforts for both the non-Medicare and Medicare accounts at the end of the 120-day collection process, the Intermediary would not have challenged University's claims for reimbursement.

Following University's extensive collection effort, the hospital wrote off all bad debts, both uncollectible Medicare and non-Medicare accounts which had exhibited no activity from the patient during the last 120 days, either in the form of some payment on the account or a promise to pay on the account.[1] Following write-

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1. University's 120-day collection policy was based upon Section 310.2 of the Medicare Provider Reimbursement Manual which was in existence in 1986 as well as prior years and provides in pertinent part the following:

> If after reasonable and customer attempts to collect the [Medicare] bill, the debt remains unpaid more than 120 days from the date the first bill was mailed to the beneficiary, the debt may be deemed uncollectible.

off, the 1986 non-Medicare accounts were referred to a collection agency for determination as to whether formal legal action should be initiated against the patients. As in prior years, the outstanding Medicare accounts were not referred to the collection agency because University had previously determined that additional collection efforts would not be cost effective. Subsequent experience corroborated University's judgment regarding the inefficiency of pursuing Medicare accounts through the collection agency after the hospital's in-house collection process. In 1989, following the Intermediary's disallowance of its 1986 reimbursement claim, University began referring Medicare bad debts to the collection agency for additional collection efforts. The resulting nominal increase in the collection of Medicare accounts was more than offset by the additional expense of the collection agency resulting in the following losses: 1989 — $34,820; 1990 — $884; and 1991 — $62.552.

Because Medicare accounts reflect only deductible and co-insurance charges, whereas non-Medicare accounts include total charges incurred by non-insured "private pay" patients, Medicare account balances tend to be smaller than non-Medicare accounts and, as the Intermediary testified during the PRRB hearing, do not warrant the intensive type collection effort appropriate for accounts with larger balances. The evidence submitted before the PRRB also establishes that University has historically been much more successful in collecting Medicare co-payments and deductibles versus non-Medicare accounts. For the years 1982 through 1991, University always collected at least 85% and in some years 90% of its Medicare co-payments and deductibles. For the year 1986, University collected 87% of its Medicare co-payments and deductibles versus 80% of its non-Medicare accounts. University recovered only an additional 3% of its non-Medicare accounts through collection agency activity.

Through a decision dated July 9, 1993, (App. at 60a) the PRRB unanimously concluded that University used reasonable

efforts to collect its 1986 Medicare bad debts and awarded reimbursement to the hospital. The Intermediary then appealed the PRRB's decision to the Health Care Financing Administration ("HCFA") which in turn entered a decision dated September 8, 1993, reversing the board's decision.[2] The HCFA concluded that University had failed to use reasonable efforts to collect its 1986 Medicare bad debts solely because of the hospital's decision to refer only its non-Medicare bad debts to a collection agency following the hospital's extensive collection efforts lasting at least 120 days. (App. at 41a). Of particular importance to this petition, the HCFA also rejected University's assertion that the Secretary was barred by the legislative moratorium contained in the Omnibus Budget Reconciliation Act of 1987 § 4008(c), as amended, from denying reimbursement for the hospital's 1986 bad debts as a result of the Secretary's acceptance of University's collection policies by reimbursement of Medicare bad debts for the years preceding 1986. Instead, the Secretary concluded that the OBRA moratorium was not applicable because University's collection efforts were not deemed to comply with her interpretation of § 310 of the Provider Reimbursement Manual requiring that providers use similar efforts to collect Medicare and non-Medicare accounts.

University then sought review of the Secretary's final decision by filing a complaint with the United States District Court for the Southern District of Georgia, Augusta Division. Recognizing the Intermediary's repeated audits and acceptances of University's collection policy for many prior years and the failure of the Medicare regulations and the Provider Reimbursement Manual ("PRM") provisions to provide clear guidance for providers, the district court granted University's summary judgment motion. In pertinent part, the district court found that the Secretary was prohibited under the OBRA moratorium from denying University's 1986 Medicare bad debt claim. (App. at 20a).

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2. The Secretary of Health and Human Services has delegated her authority to review PRRB decisions to the Administrator of the Health Care Financing Administration.

The Secretary then appealed the district court's order under 28 U.S.C. § 1291 to the Eleventh Circuit Court of Appeals. On August 28, 1997, the Eleventh Circuit entered an opinion reversing the district court's order and specifically finding that the OBRA moratorium is not applicable to the facts of this case. (App. at 1a). University timely filed a petition for rehearing which the Eleventh Circuit denied on November 26, 1997. (App. at 82a). University now petitions this honorable Court to accept certiorari in this case for the purpose of providing guidance on the proper interpretation and application of the OBRA moratorium.

REASONS FOR GRANTING THE PETITION

The paramount question presented by this petition is the appropriate interpretation and application of the legislative moratorium contained in the Omnibus Budget Reconciliation Act of 1987, § 4008(c), as amended. Specifically, what circumstances trigger application of the moratorium preventing the Secretary from effecting a change or more stringent application of Medicare reimbursement policy. This issue is not only significant to University, which stands to gain or lose approximately 1.5 million dollars in bad debt reimbursements over the course of three years, but also for other Medicare providers facing reimbursement challenges from the Secretary or her intermediaries.

At a very general level, all parties and courts which have considered the moratorium recognize that it prohibits the Secretary from imposing new or different bad debt criteria on a provider after August 1, 1987. However, the specific applications of the moratorium to actual factual scenarios differs dramatically among the courts which have addressed this issue to date.

In the case at bar, the Eleventh Circuit has concluded that "for acceptance [of the provider's bad debt practices] to trigger the terms of the moratorium, the provider's bad debt collection practices

must have been consistent with Medicare rules existing in 1987. . . ." *Id.* at 1152. Applying this standard, the Eleventh Circuit focused on whether the Secretary's current interpretation of the Medicare rules and guidelines existing on August 1, 1987 justified the decision to deny reimbursement for University's 1986 Medicare bad debts, instead of focusing on whether or not the Intermediary's acceptances of University's bad debts in prior years were reasonable in light of the Medicare rules and guidelines in existence prior to the moratorium cut-off date.

Under the Eleventh Circuit's reasoning, the moratorium is triggered only when the provider's challenged policy is in accordance with the Secretary's current, reasonable interpretation of the Medicare rules and guidelines even if the intermediary's prior acceptance of the provider's policy was also reasonably in accordance with these same rules and guidelines. Stated differently, the Eleventh Circuit has concluded that if there are two reasonable but conflicting interpretations of the applicable Medicare rules and guidelines, one supporting the prior reimbursement by the intermediary and the other resulting in the Secretary's subsequent denial of the provider's reimbursement claim, the Secretary's interpretation will prevail and the moratorium is not applicable. University submits that the analysis applied by the Eleventh Circuit is contrary to clear congressional intent and conflicts with moratorium interpretations reached by the other two circuit courts which have addressed this issue. *See Harris County Hosp. Dist. v. Shalala*, 64 F.3d 220 (5th Cir. 1995) and *Hennepin County Med. Ctr. v. Shalala*, 81 F.3d 743 (8th Cir. 1996).

I.

THE ELEVENTH CIRCUIT'S INTERPRETATION OF THE MORATORIUM IS INCONSISTENT WITH CLEAR STATUTORY LANGUAGE AND LEGISLATIVE HISTORY.

Congress has not once, but three times, expressed its intent to limit, through legislation, the Secretary's authority to deny reimbursement of a hospital's Medicare bad debts due to subsequent disagreement over collection policies which were previously accepted. As originally enacted in 1987, the pertinent portion of the statute provided the following:

> CONTINUATION OF BAD DEBT RECOGNITION FOR HOSPITAL SERVICES
>
> In making payments to hospitals under [Medicare] the Secretary of Health and Human Services shall not make any change in the policy in effect on August 1, 1987, with respect to payment . . . to providers of services for reasonable costs relating to unrecovered costs associated with unpaid deductible and co-insurance amounts. . . .

OBRA 1987, § 4008(c). Congress then amended OBRA in 1988 to clarify that the policies which the Secretary is prohibited from altering include "criteria for indigency determination procedures, for record keeping, and for determining whether to refer a claim to an external collection agency." *See* Technical and Miscellaneous Revenue Act of 1988, Pub. L. No. 100-647, § 8402.

Finally, the clearest expression of congressional intent came in 1989 when the following paragraph, in pertinent part, was added:

> The Secretary may not require a hospital to change its bad debt collection policy if a fiscal intermediary, in accordance with the rules in effect as of August 1, 1987 . . . has accepted such policy before that date, and the Secretary may not collect from the hospital on the basis of an expectation of a change in the hospital's collection policy. ,

OBRA of 1989, § 6023. The 1989 amendment is expressly stated to take effect as if included in the enactment of OBRA of 1987. *Id.*

With each amendment, the legislation became more specific and can only lead to one construction — the Secretary may not disallow Medicare bad debt claims by changing reimbursement requirements after one of her intermediaries has accepted a provider's bad debt policies in accordance with the rules in effect as of August 1, 1987. In fact, the House report accompanying the 1989 OBRA amendments, explains the legislation as follows:

> If a fiscal intermediary had *accepted* a hospital's bad debt collection policy prior to August 1, 1987, the Secretary would be prohibited from directing the hospital to change its policy, or collecting retroactively from the hospital based upon the expectation of a change in the hospital's collection policy.

(Emphasis added). H.R. Rep. No. 247, 101 st. Cong., 1st Sess. at 918 (Title X. Subt. B. 5(h) (1989)). As the statutory language and this legislative history indicate, it is the intermediary's prior acceptance, not the Secretary's express approval, of the hospital's collection policy which triggers application of OBRA's prohibition against retroactive denial of Medicare bad debt reimbursement claims.

The legislative history also explains that the moratorium was spawned by the conferees' desires to protect hospitals from recommendations being made by the Inspector General of Health and Human Services for retroactive changes to Medicare bad debt policies:

> With respect to criteria for what constitutes a reasonable bad debt collection effort, the conferees are concerned about recommendations made by the Inspector General of HHS subsequent to August 1, 1987, and actions which may be taken by the Secretary in response to those recommendations, regarding the bad debt collection policies followed by certain hospitals.
>
> The Inspector General's recommendations, for example, recommendations concerning the extent of documentation required to demonstrate indigency and the provider's responsibility regarding a decision to use a collection agency for Medicare bad debt appear to create requirements in addition to those in the Secretary's regulations, the decisions of the Provider Reimbursement Review Board, and relevant program manual and issuances.
>
> The actions taken in response to the Inspector General's recommendations may have the effect of violating the prohibition on changes in policy if the Secretary's response results in the retroactive disallowance of bad debt payments claimed by the hospitals.

H.R. Conf. Rep. No. 1104, 100th Cong. 2d Sess. 277 (1988), reprinted in U.S.C.C.A.N. 5048, 5337. As this language makes clear, Congress was addressing precisely the type of action in

which the Secretary is now engaging. The fact that Congress, through its legislation, addressed this issue not once, but three times, indicates its clear and steadfast intent to eradicate the unfair and punitive results, such as those present in this case, flowing from the Secretary's retroactive disagreement with the bad debt collection policies of hospitals which have previously been accepted by intermediaries. By looking to the past practice of the fiscal intermediary, Congress clearly took away from the Secretary the authority to change the rules for bad debt allowance, including the ability to issue new policies and applying new interpretations to existing regulations.

In enacting the moratorium, Congress intended to give providers needed certainty concerning the treatment of bad debt reimbursement. To constrain rule making authority, but leave the Secretary free to make new interpretations of existing rules, would have accomplished little. Congress recognized that at any point in the future, it would be impossible to determine how, on August 1, 1987, the Secretary would have interpreted the rules and guidelines in existence on August 1, 1987. Consequently, Congress enacted legislation which placed the decision making focus not upon how the Secretary might interpret the regulations, but rather upon the historical practice of the fiscal intermediary prior to August 1, 1987.

When Congress has unambiguously spoken, as in this case, the judiciary must carry out the legislation and an administrative agency's contrary interpretation is meaningless. *See Chevron USA, Inc. v. Natural Resources Defense Council*, 467 U.S. 837, 842-43 (1984) ("if the intent of Congress is clear, that is the end of the matter; for the court, as well as the agency, must give effect to the unambiguously expressed intent of Congress."). The unambiguous congressional language discussed above provides that the moratorium is triggered when an intermediary's prior acceptance of a bad debt collection policy is reasonably in accordance with

the Medicare rules and guidelines in existence on the moratorium cut-off date. *See Hennepin*, 81 F.3d at 751, n.6 ("preventing disallowance under the moratorium when an intermediary has accepted a provider's policy based on a reasonable interpretation of the rules in existence on August 1, 1987 is consistent both with the moratorium and the Secretary's interpretation of it") and *Harris*, 64 F.3d at 223, n.11 ("the clear intent of Congress was to prevent the HHS from forcing hospital-providers to change their policies regarding indigency determinations by withholding reimbursement for bad debts").

Nothing in the statutory language supports the Eleventh Circuit's determination that the moratorium is triggered only when the provider's bad debt collection practices are consistent with the Secretary's current interpretation of the Medicare rules and regulations in existence on August 1, 1987. Given the moratorium's unambiguous language, the Eleventh Circuit's reliance on *Auer v. Robbins*, __ U.S. __, 117 S. Ct. 905, 911 (1997) is misplaced. (App. at 7a). The extreme deference this Court gave to the Secretary's interpretation at issue in *Auer* is not appropriate when interpreting and applying the Congressional mandate expressed by the moratorium.

II.

THE ELEVENTH CIRCUIT'S DECISION IS IN CONFLICT WITH RECENT DECISIONS OF THE FIFTH AND EIGHTH CIRCUIT COURTS OF APPEALS.

A. Proper interpretation of the moratorium should focus on whether the intermediary's prior reimbursement was reasonable, not whether the Secretary's subsequent denial is reasonable.

Three Circuit Courts of Appeals have now interpreted the triggering language of the OBRA moratorium and each has reached

vastly differing results. The Eleventh Circuit's opinion below is the most restrictive and reduces three Congressional enactments to sentiment without substance. In fact, University submits that under the facts of this case, it would prevail in obtaining reimbursement under the holdings of the Eighth Circuit in *Hennepin*, 81 F.3d 743; and the Fifth Circuit in *Harris*, 64 F.3d 220.

In its decision below, the Eleventh Circuit concluded that "for acceptance to trigger the terms of the moratorium, the provider's bad debt collection practices must have been consistent with Medicare rules existing in 1987 [as presently interpreted by the Secretary]. . . ." *Id.* at 1152. The Eleventh Circuit's interpretation differs significantly from the statutory constructions reached in *Harris* and *Hennepin*. While the *Harris* and *Hennepin* circuit courts disagreed as to what activity constitutes acceptance by the Secretary, both circuits consistently found that the "in accordance" clause of the OBRA moratorium modifies the word "accepted" not "policy." *See Hennepin*, 81 F.3d at 750. Unlike the Eleventh Circuit's decision in the instant case, the triggering standard applied by the Eighth and Fifth Circuits was not whether the provider's policy was in accordance with the Secretary's interpretation of the rules existing on August 1, 1987, but rather whether the intermediary's prior acceptance of the provider's policy was reasonable in light of the rules and guidelines in effect on that date. *Hennepin*, 81 F.3d at 751.

> The Secretary may not retroactively apply a more stringent interpretation of those existing rules, *nor may she or an intermediary reopen a notice of program reimbursement if the intermediary's interpretation of the existing rules leading to the issuance of the notice was reasonable and based on sufficient information.*

(Emphasis added) *Id.* at 751. The Eighth Circuit expressly held that

> [p]reventing disallowance under the moratorium when an intermediary has accepted a provider's policy based on a reasonable interpretation of the rules in existence on August 1, 1987, is consistent both with the moratorium and the Secretary's interpretation of it.

Id. at 751, n.6. The Fifth Circuit's decision in *Harris* went further than the Eighth Circuit's holding and found that an intermediary's reimbursement of a provider's practice constitutes acceptance triggering application of the moratorium even if the provider's practice is violative of the Medicare rules and guidelines in effect on the moratorium's August 1, 1987 cut-off date. *See Harris*, 64 F.3d at 222-223.

At first blush, the distinction between the provider's policies being in accordance with the Secretary's interpretation of the rules versus the intermediary's acceptance of the provider's policies being in accordance with the rules may seem to be a semantical distinction without a real difference. However, University submits that the difference is substantial and result altering. When the triggering standard, as applied by the Eleventh Circuit below, is whether the provider's policy was in accordance with the rules in effect as of the moratorium cut-off date, the court must give extreme deference to the Secretary's interpretation. *University Health Services, Inc.*, 120 F.3d at 1148. If the Secretary's current construction of the rules is reasonable, then it must control even if there are other reasonable interpretations. *Id.* However, when the applicable standard is whether the intermediary's prior acceptance of the provider's practices was reasonable in light of the regulations, PRM provisions and PRRB decisions in existence on August 1, 1987, deference to the Secretary's *post hoc* position is not appropriate.[3]

3. The Fifth and Eighth Circuits have both concluded that the OBRA moratorium's provisions leave no interpretative "gap" to be filled by the Secretary, *Hennepin*, 81 F.3d at 749 and *Harris*, 64 F.3d at 223, and that the moratorium prevents the Secretary from applying new rules or new interpretations of existing rules. *Id.*

The Eighth Circuit in *Hennepin* addressed the very issue pending in this case and found that the provider's failure to use collection agencies to pursue its Medicare accounts could not serve as a basis for denial of reimbursement because the PRRB had previously ruled, "that it was not always necessary under existing regulations to submit the accounts of Medicare patients to outside collection agencies." *Hennepin*, 81 F.3d at 752, n.7 (citing *St. Francis Hospital and Medical Center v. Blue Cross and Blue Shield Assoc./Kansas Hospital Service Association*, PRRB Hearing Dec. No. 86-D21 (Nov. 12, 1985) and *Reed City Hospital v. Blue Cross and Blue Shield Assoc./Blue Cross and Blue Shield of Michigan*, PRRB Hearing Dec. No. 86-D67 (Feb. 20, 1986)). Given the existence of the PRRB's decisions in *St. Francis* and *Reed*, which were subsequently either implicitly or explicitly made the final determinations of the Secretary, the *Hennepin* court found that the intermediary's prior issuance of the notice of program reimbursement was reasonable acceptance of this particular aspect of the provider's Medicare bad debt collection policy, despite the Secretary's contrary arguments, and instructed the district court on remand that no additional inquiry into this issue was appropriate. *Id.*

The Secretary raised other challenges to the provider's collection policies in *Hennepin*, not present in the instant case, which the Eighth Circuit found might not be barred by the moratorium. In particular, the provider in *Hennepin* did not appropriately store information and document reasons supporting its indigency determination and did not pursue its Medicare accounts as vigorously as its non-Medicare accounts during its initial 120-day collection efforts prior to referring its non-Medicare accounts to a collection agency. *Id.* at 745-46. None of these factors are present in the instant case, and it is undisputed that University vigorously and identically pursued its Medicare and non-Medicare accounts for at least 120 days.[4]

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4. In *Hennepin*, the intermediary also decided to reopen its prior reimbursement recommendation when it discovered evidence of the (Cont'd)

B. Application of the interpretations announced in *Hennepin* and *Harris* would result in triggering the moratorium based upon the facts of this case.

While the Eleventh Circuit indicated that it was adopting the reasoning advanced in *Hennepin*, (*University Health Services, Inc.* at 1153), the court's holding is directly contrary to the result reached by the Eighth Circuit. Unlike *Hennepin*, the Eleventh Circuit refused to consider whether the Intermediary's prior acceptance of University's collection policy was reasonable in light of the PRRB's decisions in *St. Francis* and *Reed*. The court instead focused solely upon whether the Secretary's decision to deny reimbursement is reasonable in light of the Secretary's current interpretation of the Medicare rules and regulations. The Eleventh Circuit did not even address the Eighth Circuit's determination that the decisions in *St. Francis* and *Reed* in conjunction with the legislative moratorium foreclose the Secretary from challenging the provider's decision not to refer Medicare accounts to collection agencies at the conclusion of its in-house collection efforts.

In both *St. Francis* and *Reed*, the PRRB held that the providers' decisions not to refer Medicare accounts to a collection agency after in-house collections were reasonable when further pursuit of the accounts through collection agencies would be too costly. (App. at 87a and 98a). In both cases, the provider's in-house collection

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(Cont'd)
provider's affirmative misrepresentation regarding its bad debt collection policies. With this evidence of affirmative misrepresentation, it is easy to understand and accept the justice in holding that the intermediary's prior reimbursement determinations, based upon its reliance on the provider's misrepresented policies, did not constitute "acceptance" for purposes of triggering the moratorium. *Hennepin* at 746. In the case at bar, there is absolutely no evidence or even any intimation that University has ever misrepresented any aspect of its bad debt collection policy.

efforts were less intensive than University's. For example, the provider in *Reed* only pursued in-house collections of Medicare accounts for 90 days as opposed to University's pursuit of these accounts for at least 120 days. The in-house collection policies at issue in *St. Francis* did not include telephone calls to Medicare patients with outstanding accounts as do University's collection policies. Yet, in both cases, the PRRB found that the provider's collection policies were reasonable and in accordance with the Medicare rules and regulations. The administrator of the HCFA subsequently affirmed the PRRB's decision in *St. Francis* through its decision dated January 8, 1986. (App. at 93a). The Board's decision in *Reed* also subsequently became the Secretary's final decision because she declined to review it.

Although the Eleventh Circuit did not consider whether the holdings in *Reed* and *St. Francis* controlled the instant dispute, the PRRB has concluded that they do. In its decision for University's 1987 cost year, which contains identical issues to the 1986 cost report at issue here, the PRRB stated that

> [a]lthough the facts in the instant case may not be identical to those in either *Reed* or *St. Francis*, they match on what the Board considers the essential finding in each of these cases.

(App. at 117a). The Eleventh Circuit's holding in the instant appeal that *Reed* and *St. Francis* "constitutes specific applications" which "do not dictate a given result" is also directly contrary to the Eighth Circuit's decision in *Hennepin*. *See University Health Services, Inc.* at 1151, n.4 and *Hennepin*, 81 F.3d at 752, n.7.

The facts of the instant case would also trigger application of the moratorium under the standard described by the Fifth Circuit in *Harris*. The *Harris* court goes further than the Eighth Circuit's

opinion in *Hennepin*, by holding that the intermediary's prior payment of the provider's Medicare bad debt claims triggers application of the OBRA moratorium even if the hospital's collection policies violate applicable Medicare guidelines and regulations. *Harris*, 64 F.3d at 223, n.11. Explaining its decision, the Fifth Circuit noted the following:

> The Secretary also argues that even if BCBS [Intermediary] accepted the Hospital's policies, that acceptance cannot excuse violations of the applicable guidelines and regulations. That interpretation of the OBRA, however, is inconsistent with its language.

Id. at 223, n.11.[5]

C. The great differences between the circuit court opinions indicate the need for guidance from this Court.

When one compares the moratorium interpretations reached by the three circuit courts which have addressed the issue, the differences become very apparent. The three opinions can best be summarized as follows:

> (1) **FIFTH CIRCUIT** — An intermediary's prior reimbursement constitutes acceptance of the

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5. The Eleventh Circuit in the case at bar indicates that perhaps the intermediary in *Harris* had more information available to it in making the decision to reimburse the provider than the intermediary had in reimbursing University's bad debts for prior years. *See University Health Services, Inc.*, 120 F.3d at 1153, n.5. However, the evidence outlined in the *Harris* district court's decision indicates the contrary. As the district court in *Harris* notes, the Secretary in that case argued that the intermediary's prior audits never mentioned the provider's indigency policy which was under scrutiny. *Harris County Hospital District v. Shalala*, 863 F. Supp. 404, 409 (S.D. Tex. 1994).

provider's practice and triggers application of the moratorium **even if that practice is in violation of the Medicare rules and regulations in existence as of August 1, 1987**. *Harris*, 64 F.3d at 223, n.11.

(2) **EIGHTH CIRCUIT** — The intermediary's prior reimbursement constitutes acceptance triggering the moratorium as long as the **acceptance is reasonably in accordance with the Medicare rules and guidelines in existence as of August 1, 1987. The Secretary's current interpretation of those rules and guidelines is not determinative**. *Hennepin*, 81 F.3d at 751.

(3) ***ELEVENTH CIRCUIT*** — The moratorium is triggered only when the **provider's policy is in accordance with the Secretary's current, reasonable interpretation of Medicare rules and guidelines in effect on August 1, 1987 regardless of whether the intermediary's prior reimbursement was also reasonably in accordance with these rules and guidelines**. *University Health Services, Inc.*, 120 F.3d at 1153.

Given the stark contrast between these interpretations, guidance from this Court on the proper trigger of the OBRA moratorium is greatly needed and this petition should be granted.

D. The Eleventh Circuit's opinion is in conflict with moratorium interpretations of the Fifth and Eighth Circuits, as well as the HCFA.

Although the Fifth and Eighth Circuits have disagreed regarding whether the intermediary's prior acceptance must be in compliance with the Medicare rules and guidelines in existence as

of August 1, 1987, both circuits have agreed upon key factors which are contrary to the Eleventh Circuit's opinion below. First, both circuits focused their inquiry on what was reasonable at the time that the intermediary previously issued a notice of program reimbursement and thereby accepted the provider's Medicare collection policy. Both circuits concluded that the "in accordance" clause of the OBRA moratorium modifies the word "accepted," not "policy." *Hennepin* at 750. As a result, both circuits found that the moratorium bars the Secretary from subsequently denying reimbursement when an intermediary's issuance of reimbursement in prior years was reasonable in light of Medicare rules and guidelines in existence on August 1, 1987. *Hennepin* at 751.

The Fifth and Eighth Circuits have also recognized that a notice of program reimbursement, like the ones repeatedly received by University for many years prior to 1986, are the only tangible forms of acceptance that a provider can expect from the Secretary and/or her intermediary. *Hennepin*, 81 F.3d at 749 and *Harris*, 64 F.3d at 222.

> In the majority of cases, the notice of program reimbursement is the final consideration of a policy by an intermediary. A conclusion that a notice of program reimbursement cannot constitute an acceptance is therefore untenable.

Hennepin, 81 F.3d at 749.

The Secretary has also interpreted the moratorium in a manner similar to the Eighth Circuit's construction in *Hennepin*. Citing a June 11, 1990 memorandum from the Health Care Financing Administration ("HCFA") to its regional administrators, the Eighth Circuit stated the following:

> [p]reventing disallowance under the moratorium when an intermediary has accepted a provider's

> policy based on a reasonable interpretation of the rules in existence on August 1, 1987, is consistent both with the moratorium and the Secretary's interpretation of it.

Hennepin, 81 F.3d at 751, n.6. As reflected in its 1990 memorandum, the HCFA concluded that the OBRA moratorium prevented an intermediary from denying reimbursement for a provider's Medicare bad debts sent to a collection agency when the intermediary had previously reimbursed such claims. (App. at 111a). The HCFA reached this conclusion despite the fact that it had

> always believed . . . that claiming of a Medicare bad debt at the point of sending the account to the [collection] agency would be contrary to the bad debt policy in sections 308 and 310 [of the Provider Reimbursement Manual].

(App. 112a). Accordingly, as recognized by the HCFA, as well as the Fifth and Eighth Circuits, the intermediary's prior reasonable allowance of reimbursement, even though it may be at odds with the Secretary's past and current interpretation of the rules and guidelines in effect, is sufficient to trigger application of the moratorium.

CONCLUSION

The Eleventh Circuit erred by refusing to consider whether the Intermediary's prior reimbursements of University's Medicare bad debts were reasonable given the Medicare rules and guidelines, including the PRRB decisions in *St. Francis* and *Reed*. If the Eleventh Circuit had applied the appropriate trigger standard for the OBRA moratorium, it would have reached the same conclusion as the Eighth Circuit in *Hennepin*, *i.e.* that the intermediary's prior acceptance of the hospital's policy not to send Medicare accounts to a collection agency following extensive in-house treatment was reasonably in accordance with the Medicare rules, regulations and PRRB decisions in existence.

For the reasons set forth above, Petitioner respectfully submits that the petition for a writ of certiorari should be granted.

Respectfully submitted,

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APPENDIX

APPENDIX A — OPINION OF THE UNITED STATES COURT OF APPEALS FOR THE ELEVENTH CIRCUIT DATED AUGUST 28, 1997

UNIVERSITY HEALTH SERVICES, INC., Plaintiff-Appellee,

v.

HEALTH & HUMAN SERVICES, Donna Shalala, in her official capacity as Secretary, Defendant-Appellant.

No. 95-9493.

United States Court of Appeals,
Eleventh Circuit.
Aug. 28, 1997.

* * *

Appeal from the United States District Court for the Southern District of Georgia.

(No. CV193-180),

Dudley H. Bowen, Jr., Judge.

Before BIRCH, BLACK and CARNES, Circuit Judges.

BIRCH, Circuit Judge:

This appeal requires that we examine regulations and interpretive guidelines promulgated pursuant to Title XVIII of the Social Security Act, 42 U.S.C. §§ 1395-1395cc ("the Medicare Act"). The Secretary of Health and Human Services ("Secretary") appeals the judgment of the district court in favor

of University Health Services ("University"). University sought review in the district court of the Secretary's decision to disallow a portion of its claims for reimbursement of bad debts related to Medicare patients. The district court determined that the Secretary was precluded from disallowing University's bad debt claims and granted summary judgment in favor of University. For the reasons that follow, we REVERSE.

I. BACKGROUND

The Medicare Act permits hospitals and other health care providers to enter into an agreement with the Secretary by which the Secretary reimburses providers through private fiscal intermediaries for amounts owed, but not paid, by Medicare patients. 42 U.S.C. § 1395cc. To qualify for reimbursement with respect to these bad debt claims, hospitals must comply with regulations directing them to make reasonable efforts to collect Medicare deductible and coinsurance amounts. Specifically, Medicare bad debt constitutes an allowable cost if the following criteria are met:

> (1) The debt must be related to covered services and derived from deductible and coinsurance amounts.
>
> (2) The provider must be able to establish that reasonable collection efforts were made.
>
> (3) The debt was actually uncollectible when claimed as worthless.
>
> (4) Sound business judgment established that there was no likelihood of recovery at any time in the future.

42 C.F.R. § 413.80(e).

Appendix A

The Secretary has delineated further the regulation's bad debt collections requirement in its Provider Reimbursement Manual ("PRM"). Provisions of the PRM relevant to this action state in pertinent part:

To be considered a reasonable collection effort, a provider's effort to collect Medicare deductible and coinsurance amounts must be similar to the effort the provider puts forth to collect comparable amounts for non-Medicare patients. . . .

> A. Collection Agencies. — A provider's collection effort may include the use of a collection agency in addition to or in lieu of subsequent billings, follow-up letters, telephone and personal contacts. Where a collection agency is used, Medicare expects the provider to refer all uncollected patient charges of like amount to the agency without regard to class of patient. The "like amount" requirement may include uncollected charges above a specified minimum amount. Therefore, if a provider refers to a collection agency its uncollected non-Medicare patient charges which in amount are comparable to the individual Medicare deductible and coinsurance amounts due the provider from its Medicare patient, Medicare requires the provider to also refer its uncollected Medicare deductible and coinsurance amounts to the collection agency.

PRM § 310.

> Presumption of Noncollectibility. — If after reasonable and customary attempts to collect a bill, the debt remains unpaid more than 120 days from

> the date the first bill is mailed to the beneficiary, the debt may be deemed uncollectible.

PRM § 310.2.

In 1987, Congress enacted the Omnibus Budget Reconciliation Act ("OBRA") that placed a moratorium on, among other things, the Secretary's authority retroactively to modify Medicare bad debt reimbursement policy that was in effect on August 1, 1987. The moratorium provides, in pertinent part:

> In making payments to hospitals under [the Medicare Program], the Secretary of Health and Human Services shall not make any change in the policy in effect on August 1, 1987, with respect to payment under [the Medicare program] to providers of service for reasonable costs relating to unrecovered costs associated with unpaid deductible and coinsurance amounts incurred under [the Medicare program] (including criteria for what constitutes a reasonable collection effort, including criteria for indigency determination procedures, for record keeping, and for determining whether to refer a claim to an external collection agency).
>
> The Secretary may not require a hospital to change its bad debt collection policy if a fiscal intermediary, in accordance with the rules in effect as of August 1, 1987, with respect to criteria for indigency determination procedures, record keeping, and determining whether to refer a claim to an external collection agency, has accepted such policy before

> that date, and the Secretary may not collect from the hospital on the basis of an expectation of a change in the hospital's collection policy.

OBRA of 1987, Pub.L. No. 100-203, § 4008(c), as amended by Technical and Miscellaneous Revenue Act of 1988, § 8402 and OBRA of 1989, § 6023.

University is a non-profit hospital located in Augusta, Georgia. The intermediary in this case is Blue Cross and Blue Shield of Georgia ("Blue Cross"). It is undisputed that University historically has pursued comparable in-house collection efforts for both Medicare and non-Medicare accounts for the first 120 days after the last activity on each account, consistent with the applicable Medicare regulations. Until 1989, University wrote off as bad debt all delinquent accounts following this 120-day period and referred all non-Medicare accounts to an in-house collection agency. University did not forward outstanding Medicare accounts to the collection agency but, rather, claimed and received, through Blue Cross, reimbursement for these amounts from the Medicare program. In 1989, Blue Cross conducted a full audit of the 1986 cost year and determined that University's bad debt collection practice, specifically with respect to the referral of solely non-Medicare overdue accounts to a collection agency, was inconsistent with Medicare policy. Accordingly, Blue Cross disallowed the 1986 bad debt claim.

University sought administrative review of Blue Cross's decision. The Provider Reimbursement Review Board ("PRRB") found that University had demonstrated that sound business judgment justified its dissimilar treatment of Medicare and non-Medicare accounts after 120 days following the last

activity on these accounts. In support of its findings, the PRRB noted that University had shown financial losses in connection with collection efforts in the 1989-1991 cost years, during which University complied with the intermediary's directive to refer all accounts, both Medicare and non-Medicare, to its internal collection agency.

The Secretary reversed the PRRB decision and concluded that University had failed to show that it had engaged in reasonable collection efforts with respect to its Medicare accounts. The Secretary premised her conclusion on the grounds that (1) University's bad debt collection method was inconsistent with the plain language of the Secretary's interpretive guidelines of the Medicare Act, embodied in the PRM, directing providers to treat similarly Medicare and non- Medicare overdue accounts; (2) University had failed to show that sound business judgment justified its decision not to refer Medicare accounts to its collection agency; and (3) because University had not acted in compliance with the pertinent Medicare regulations in 1986, the moratorium articulated in OBRA did not apply to the facts of this case and, thus, did not bar the intermediary's disallowance of reimbursement costs for that cost year.

The district court reversed the Secretary's decision and ordered that summary judgment enter in favor of University. The court found that, for many years prior to 1986, University had employed the same collection practices as those used in 1986 and that Blue Cross previously had allowed reimbursement of University's bad debt claims. The court further stated that the Secretary tacitly had ratified University's collection efforts through the acts of her intermediary and, consequently, her change in policy with respect to the 1986 cost year had an unfair retroactive effect. Based on this reasoning, the court

concluded that the Secretary was equitably estopped from disallowing reimbursement for 1986. Alternatively, the court found that the OBRA moratorium barred the Secretary from denying University's claim for bad debt reimbursement. This appeal followed.

II. DISCUSSION

"In reviewing the Secretary's decisions, both the district court and [our] court must abide by those decisions 'unless [they are] arbitrary, capricious, an abuse of discretion, not in accordance with law, or unsupported by substantial evidence in the record taken as a whole.' " Alacare Home Health Serv., Inc. v. Sullivan, 891 F.2d 850, 854 (11th Cir.1990) (quoting Carraway Methodist Med. Center v. Heckler, 753 F.2d 1006, 1009 (11th Cir.1985)) (alteration in original). "We previously have noted that the Secretary has amassed considerable expertise in the health care area and absent a strong showing by the plaintiff, 'this court will not substitute its judgment for that of the agency.' " Id. (quoting Lloyd Noland Hosp. & Clinic v. Heckler, 762 F.2d 1561, 1565 (11th Cir.1985). Although an agency's interpretive rules do not have the force of law, Shalala v. St. Paul-Ramsey Med. Ctr., 50 F.3d 522, 527 n. 4 (8th Cir.1995), the Secretary's interpretation of her own regulations are "controlling unless plainly erroneous or inconsistent with the regulation," Auer v. Robbins, __ U.S. __, __, 117 S.Ct. 905, 911, 137 L.Ed.2d 79 (1997) (internal quotation marks omitted)).

The Secretary advances several arguments on appeal in support of the request that her decision to disallow University's bad debt reimbursement claim for the 1986 fiscal year be upheld: (1) because the plain language of the applicable regulations

and PRM provisions prohibit dissimilar treatment of Medicare and non-Medicare outstanding accounts, and the intermediary only learned of University's bad debt collection practices after a full audit in 1989, the Secretary's disallowance of the 1986 reimbursement claim was fair, consistent with the regulations, and did not constitute retroactive, unfair rulemaking; (2) the legislative moratorium on disallowance of Medicare bad debts was not triggered under the facts of this case; and (3) the record does not adequately support University's contention that its bad debt collection practices were justified by sound business judgment.[1] University responds that the Secretary's decision is arbitrary, capricious, and in conflict with both Medicare policy and OBRA. We address each of these arguments in turn.

A. Fairness of Secretary's Decision

University submits, in essence, that the Secretary's decision in this case is unfair. This argument consists of three facets: (1) the Secretary's decision is based on an unreasonable interpretation of the governing interpretive rules; (2) the Secretary's retroactive disallowance of the reimbursement claim constitutes retroactive rulemaking and, thus, is arbitrary and not entitled to deference; and (3) the decision is not supported by substantial evidence and, if permitted to stand, would conflict with the policy underlying the applicable Medicare regulation.

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1. Although the Secretary also takes issue with the district court's analysis with respect to equitable estoppel, University does not squarely present this argument in its brief and appears to not rely on it as a basis for affirming the district court's judgment. We note, in addition, that equitable estoppel against the government does not serve as an appropriate legal theory on which to base reversal of the Secretary's decision in this case. We therefore deem this argument to be abandoned and, more importantly without merit.

We disagree. The administrative guidelines germane to this action are found in PRM §§ 310 and 310.2, outlined above. These rules guide both a provider and intermediary as to what constitutes reasonable collection efforts, on the one hand, and the point in time at which a debt may be deemed uncollectible, on the other hand. The only issue in this case is whether University pursued reasonable collection efforts with respect to its Medicare accounts; this is the subject solely of PRM § 310, which unambiguously directs providers to treat similarly uncollected charges of Medicare and non-Medicare patients. University contends that PRM § 310 read in tandem with PRM § 310.2, which deems a debt uncollectible if unpaid beyond 120 days after the last activity on an account, is subject to only one logical interpretation: that is, once a provider has pursued Medicare and non-Medicare accounts equally for the first 120 days, it then may deem both accounts to be uncollectible and refer only non-Medicare accounts to a collection agency.[2] Under the Secretary's reading of the two relevant provisions, however, PRM § 310 requires similar treatment of all patient accounts of comparable size regardless of the point in time at which the collection effort is measured. PRM § 310.2 does not come into

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2. University further suggests that a provider may engage in this debt collection practice if the decision to do so is supported by sound business reasons. In adding this requirement, University appears to concede that its practice of treating uncollected Medicare and non-Medicare accounts dissimilarly, in the absence of a financial justification, see 42 C.F.R. § 413.80(e)(4), does not comply with PRM § 310. Assuming that a showing of sound business judgment may, in certain circumstances, justifying non-compliance with the rule at issue this fact does not alter our reading of that rule. At any rate, the Secretary determined that University had failed adequately to demonstrate that its practice was supported by sound business judgment. We discuss this aspect of the Secretary's decision in greater detail below.

effect unless the provider has complied with PRM § 310 in treating identically all Medicare and non-Medicare accounts and has ceased collection efforts with regard to all accounts after 120 days.

We find the Secretary's interpretation of PRM §§ 310 and 310.2 to be entirely plausible and consistent with the regulation's directive that a provider expend reasonable collection efforts before claiming and receiving reimbursement from the Medicare program for uncollected charges. The undisputed purpose of this requirement is to ensure that a provider treat similarly those accounts for which the provider has no guarantor as those for which the government acts as guarantor. Compliance with this policy presumably prevents Medicare from being used as a payor for unpaid bills that might yet be paid by the responsible party. We cannot conclude that the Secretary's interpretation of the PRM guidelines drafted pursuant to the "reasonable collection effort" regulation is arbitrary, plainly erroneous, or inconsistent with Medicare policy. We therefore are bound to give controlling weight to the Secretary's interpretation of the governing regulation and accompanying guidelines. See Thomas Jefferson Univ. v. Shalala, 512 U.S. 504, 512, 114 S.Ct. 2381, 2386, 129 L.Ed.2d 405 (1994).

We similarly are unpersuaded by University's suggestion that, because the intermediary previously had allowed University's claims for reimbursement, the Secretary's subsequent disallowance of the claim constitutes unfair, retroactive rulemaking. It is undisputed that the PRM guidelines relevant to this case were available to University prior to the 1986 fiscal year. It also is undisputed that Blue Cross first discovered University's bad debt collection practices and its concomitant non-compliance with PRM § 310 in its 1989 full audit of the 1986 cost year; there is no allegation or indication

that Blue Cross had been supplied with the necessary information to discover University's practices prior to the audit. The intermediary thus discovered new, material information previously unavailable to it that informed its decision to disallow certain claims not in conformity with governing Medicare rules and policies. University fails to demonstrate how this decision constitutes a substantive change or a different application of the Secretary's policy prohibiting dissimilar treatment of Medicare and non-Medicare accounts as embodied in PRM § 310.[3]

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3. In support of the proposition that its 1986 bad debt collection efforts were reasonable, University points to a memorandum issued in 1990 by the Health Care Financing Administration clarifying PRM § 310.2 in light of the OBRA moratorium. The memorandum states, in relevant part: We believe that an intermediary could reasonably have interpreted the title of section 310.2, Presumption of Noncollectibility, to provide that an uncollectible account could be presumed to be a bad debt if the provider has made a reasonable and customary attempt to collect the bill for at least 120 days even though the claim has been referred to a collection agency. Such an interpretation is reasonable unless it is apparent that the debt is not a bad debt, for example, because the beneficiary is currently making payments on account, or has currently promised to pay the debt.

University contends that this passage ratifies University's interpretation of the applicable guidelines and confirms that the language of the PRM is ambiguous. However, as noted by the Secretary, the clarifying memorandum refers expressly to PRM § 310.2, which is not at issue in this case. The memorandum also explicitly emphasizes that, notwithstanding any possible confusion with regard to PRM § 310.2, "the bad debt policy is otherwise unaffected by the above discussion." Contrary to University's position, we do not find that the above-memorandum shows either that the Secretary has acted arbitrarily here or that the provider is not necessarily required to treat similarly Medicare and non-Medicare accounts.

Finally, we note briefly that the Secretary's decision not to credit University's business reasons as justifying non-compliance with the similar-treatment policy with respect to Medicare and non-Medicare accounts is supported by substantial evidence. In support of its business-related justification, the Secretary found that University relied principally on "(1) historical evidence showing that the Provider was more successful in collecting amounts due from Medicare accounts than from non-Medicare accounts; and (2) a generalized perception that the Medicare patients would likely either pay their deductible and coinsurance obligations during the initial 120-day collection period or would not be inclined or able to pay." R2-11 (footnote omitted). In addition, the Secretary considered evidence submitted by University indicating that costs with respect to collection efforts increased in the 1989-1991 fiscal years, during which University referred both Medicare and non-Medicare accounts to its collection agency. Significantly, the Secretary determined that, although University had provided some financial rationale for its decision to treat dissimilarly Medicare and non-Medicare accounts after 120 days, its stated reasons were largely speculative, inconclusive, and inconsistent.

We need not express a view as to whether we agree or disagree with the Secretary's determination. Our review of the record reveals that the Secretary's conclusion that University failed adequately to show that it had engaged in reasonable collection efforts based on sound business judgment is supported by substantial evidence. See Bama Tomato Co. v. U.S. Dept. of Agric., 112 F.3d 1542, 1546 (11th Cir.1997) ("Substantial evidence means 'such relevant evidence as a reasonable mind might accept as adequate to support a conclusion.' ") (quoting Consolidated Edison Co. v. NLRB, 305 U.S. 197, 229, 59 S.Ct. 206, 217, 83 L.Ed. 126 (1938)). Although University

submitted evidence of some increased costs in the 1989-1991 fiscal years, it did not conclusively demonstrate that these increased costs would have been incurred in 1986 if Medicare accounts had been referred along with non-Medicare accounts. Moreover, the Secretary noted but dismissed as speculative University's assertion that, based on its experience in the community, pursuit of Medicare patients who had not paid their accounts after 120 days was not likely to result in further recovery; we cannot say that the Secretary's conclusion in this regard is insupportable.[4] In sum, we find that the Secretary's

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4. At oral argument, University argued that two former PRRB decisions, St. Francis Hosp. and Med. Ctr. v. Blue Cross and Blue Shield Ass'n/Kansas Hosp. Ass'n, PRRB Decision No. 86-D21 (Nov. 12, 1985), and Reed City Hosp. v. Blue Cross and Blue Shield Ass'n, PRRB Decision No. 86-D21 (Feb. 20, 1986), in which the PRRB found that sound business judgment justified dissimilar treatment of Medicare and non-Medicare bad debt claims, constitute the Secretary's expression of policy and, thus, mandate that the Secretary reach the same determination with respect to the facts of this case. Although it is true that, given the facts and records presented in connection with St. Francis Hospital and Reed City Hospital, the Secretary found that the providers had engaged in reasonable business practices notwithstanding their dissimilar treatment of Medicare and non-Medicare accounts, these decisions constitute specific applications of the relevant regulations and guidelines and, therefore, do not dictate a given result in light of the specific circumstances presented here. Slated differently, the records in St. Francis Hospital and Reed City Hospital apparently supported the providers' contentions that sound business judgment justified their respective treatment of Medicare accounts; in this case, the Secretary found that the record and hearing testimony were inadequate to support the same claim. Because we cannot say the Secretary's decision is inconsistent with the weight of the administrative record in connection with this case, any further inquiry regarding University's sound-business-judgment justification necessarily must end.

determination that University had failed adequately to support its dissimilar treatment of Medicare and non-Medicare accounts is supported by the record and, therefore, must be affirmed on that basis.

B. Effect of Legislative Moratorium (OBRA)

As an alternative basis on which to grant summary judgment in favor of University, the district court found that the legislative moratorium embodied in OBRA of 1987, as amended, barred the Secretary's retroactive disallowance of Medicare bad debt reimbursement for fiscal year 1986. As previously noted, the moratorium prohibits the Secretary from imposing new or different bad debt criteria on a provider after August 1, 1987, if the intermediary had "accepted" the provider's policies before that date in accordance with the rules then in effect. The district court reasoned that Blue Cross's previous allowance of University's bad debt claims constituted acceptance of University's bad debt criteria. The court further determined that, because University's bad debt collection practices were reasonable and consistent with PRM §§ 310 and 310.2, they were in accordance with the rules in effect prior to the moratorium.

University essentially reiterates on appeal the district court's discussion and adds that the Secretary's retroactive disallowance would constitute an application of either a new rule or a more stringent version of the rule known to the provider prior to OBRA's enactment. University again suggests that the Secretary's reading of PRM § 310 is strained and gives rise to a substantive retroactive modification of Medicare policy that OBRA was intended to prevent.

Appendix A

The Secretary argues that OBRA is not triggered under the facts of this case. The Secretary suggests that the intermediary's previous allowance of University's bad debt claim cannot be construed as acceptance pursuant to OBRA because (1) acceptance must be express and based on full, accurate information, unavailable to Blue Cross in this instance until after a full audit; (2) even if the intermediary's allowance of a claim is deemed to be equivalent to tacit acceptance by the Secretary, the intermediary's approval of a provider's bad debt collection practice is ineffective if the practice later is found to be inconsistent with Medicare policy and rules; and (3) the moratorium prohibits the Secretary from requiring a provider to change its bad debt policy (assuming a fiscal intermediary previously has accepted such policy) with respect to referral of claims to an external collection agency; the collection agency used by University was in-house and, therefore, not within the scope of OBRA.

Two circuits courts to have addressed the effect of OBRA on retroactive disallowance of Medicare bad debt claims have reached somewhat conflicting (though not necessarily contrary) results. Harris County Hospital District v. Shalala, 64 F.3d 220 (5th Cir.1995), relied on by University, involved the Secretary's decision retroactively to disallow a hospital's Medicare bad debt claim based on the hospital's alleged non-compliance with regulations outlining the method of determining whether a patient is indigent. The Fifth Circuit held that, although OBRA does not explicitly define the term "acceptance," an intermediary's previous repayment of a provider's claim for Medicare reimbursement of bad debt following an investigation and audit constitutes "acceptance" for purposes of triggering the moratorium. Id. at 222. Because the acceptance occurred prior to August 1, 1987, OBRA barred the Secretary from later disallowing an earlier claim for reimbursement. See id.

Appendix A

Hennepin County Medical Center v. Shalala, 81 F.3d 743 (8th Cir.1996), concerned the Secretary's decision to reopen and re-audit its recommendation for reimbursement for a previous fiscal year based on new information indicating that the hospital had not engaged in equally vigorous collection efforts with respect to Medicare and non-Medicare accounts prior to the 120-day mark. The Eighth Circuit observed that, because "[a] notice of program reimbursement and the reimbursement that flows from it, are the only tangible forms of acceptance a provider can expect from an intermediary," allowance of a bad debt claim by an intermediary could, in the majority of cases, function as a form of acceptance of the provider's bad debt practices. Id. at 749. The court further held, however, that

> [a] reimbursement notice will not always be equivalent to an acceptance. . . . Congress enacted the moratorium with the intention of preserving the bad debt reimbursement rules and regulations as they existed prior to August 1, 1987. . . .
>
> If issuance of a notice of program reimbursement were invariably an acceptance . . . . the reopening regulation and others issued before August 1, 1987 would be superfluous. This would frustrate the intent of Congress that existing regulations be enforced.

Id. The court also interpreted OBRA's requirement that acceptance be "in accordance with the rules in effect as of August 1, 1987" to mean that, for acceptance to trigger the terms of the moratorium, the provider's bad debt collection practices must have been consistent with Medicare rules existing in 1987:

> In passing the moratorium, Congress was motivated to prevent unexpected consequences to

> providers from the inspector general's proposed changes in the criteria for bad debt reimbursement. Permitting correction of errors made by intermediaries in the application of rules existing on August 1, 1987 is consistent with that policy. It appears Congress merely sought to freeze a moment in time, forbidding the Secretary to change the criteria after that date, but allowing full enforcement of the policies before it.
>
> . . . .
>
> We conclude on this analysis that Congress intended the moratorium to apply only where a provider was in compliance with rules existing on August 1, 1987, as embodied in the regulations, the PRM, and PRRB decisions.

Id. at 751.

We find the reasoning advanced by the Eighth Circuit in Hennepin to be persuasive and, therefore, adopt it in light of the facts of this case.[5] As noted by that court, in the vast majority of cases, an intermediary's allowance of a claim remains

5. Significantly, the Hennepin court noted that its decision might not be directly contrary to that reached by the Fifth Circuit in Harris. See Hennepin, 81 F.3d at 750 n. 4. In Harris, the intermediary already had conducted an audit before allowing the provider's bad debt claim. The decision does not indicate whether the audit specifically targeted the provider's Medicare bad debt collection practices, nor is there any suggestion that new, material evidence had been made available to the intermediary subsequent to its allowance. Harris, therefore, is factually distinguishable from both Hennepin and the instant case.

unchallenged and undisturbed; it therefore serves as the functional equivalent of acceptance of the provider's claim in those cases. Where the intermediary conducts a full audit and discovers new, previously unavailable information indicating that the provider's practices were not consistent with Medicare rules and guidelines in existence prior to August 1, 1987, however, the moratorium is not triggered and retroactive disallowance may be appropriate. We also reject University's restatement of the proposition that the Secretary's disallowance of its Medicare bad debt claim constitutes either a new substantive rule or a stiffer application of a pre-existing rule; as discussed previously, we do not view the Secretary's application of PRM § 310 in this instance to be tantamount to rulemaking, nor is it an unfair, inconsistent application of a policy not previously known to providers. We conclude that the Secretary's disallowance of University's Medicare bad debt claim for the 1986 fiscal year is not barred by the OBRA moratorium.

III. CONCLUSION

In this appeal, the Secretary asks that we affirm the decision to disallow retroactively University's Medicare bad debt claim for the cost year 1986. The Secretary bases this retroactive disallowance on evidence acquired by the fiscal intermediary in connection with a 1989 full audit of University's Medicare bad debt collection practices indicating that University had failed to engage in reasonable collection efforts of unpaid Medicare accounts. More specifically, it is undisputed that, during the audit, the intermediary discovered that University had not treated similarly Medicare and non-Medicare accounts that remained outstanding following a 120-day billing cycle. University contends that the Secretary's disallowance constitutes unfair, retroactive rulemaking and is barred by the OBRA moratorium

of 1987. We conclude that the Secretary's decision is (1) neither arbitrary nor inconsistent with the governing Medicare policies, rules, and guidelines; (2) supported by substantial evidence adduced in the administrative record; and (3) not barred by the legislative moratorium embodied in OBRA of 1987. Accordingly, we REVERSE the district court's order and REMAND with instructions to enter judgment in favor of the Secretary.

APPENDIX B — ORDER AND JUDGMENT OF THE UNITED STATES DISTRICT COURT FOR THE SOUTHERN DISTRICT OF GEORGIA, AUGUSTA DIVISION FILED SEPTEMBER 28, 1995

IN THE UNITED STATES DISTRICT COURT

FOR THE SOUTHERN DISTRICT OF GEORGIA

AUGUSTA DIVISION

CV 193-180

UNIVERSITY HEALTH SERVICES, INC.,

Plaintiff,

v.

DONNA E . SHALALA, Secretary of Health and Human Services,

Defendant.

ORDER

Plaintiff University Health Services, Inc. ("University"), a certified provider of Medicare services, filed this civil action pursuant to 42 U.S.C. § 139500(f)(1), seeking judicial review of an adverse final decision rendered by the Secretary of Health and Human Services ("Secretary") denying University's fiscal year 1986 claim for Medicare "bad debts," those deductible and co-insurance amounts that are uncollectible from Medicare beneficiaries after reasonable collection efforts. Each party has for summary judgment, arguing respectively that there are no

genuine issues of material fact and that it is entitled to judgment as a matter of law. For reasons set forth more fully below, the Court finds that there are no genuine issues of material fact and that University is entitled to judgment as a matter of law. Therefore, University's Motion for Summary Judgment is GRANTED and the Secretary's Motion for Summary Judgment is DENIED.

I. BACKGROUND

University, a non-profit, tax-exempt hospital in Augusta, Georgia, is a certified Medicare provider. Medicare pays for most of the cost of treatment provided to beneficiaries, who are required to pay only deductible and co-insurance amounts. When these amounts remain unpaid despite collection efforts, they are termed "bad debt." *See* 42 C.F.R. §§ 409.80-89; 410.152; 410.160. The Medicare regulations permit providers such as University to recoup Medicare "bad debt" if they have been unsuccessful despite making reasonable efforts to collect. *See* 42 C.F.R. § 413.80(e).

In 1986 and for many years before, University employed the following practice with respect to both Medicare and non-Medicare accounts. For at least 120 days after the last activity — either a payment or a promise to pay — of an account, University would employ the same collection efforts with respect to both Medicare and non-Medicare unpaid debts. Regardless of type, if an account failed to show activity after 120 days it was written off. Non-Medicare accounts were then referred to University's in-house collection agency, Collections Limited, for additional collection efforts, which usually took the form of legal action. Medicare accounts were not referred to

Collections Limited[1]. Instead, University would seek reimbursement for these unpaid Medicare accounts from the Medicare program.

Following the end of fiscal year 1986, University filed a cost report with its fiscal intermediary, Blue Cross and Blue Shield of Georgia ("Blue Cross").[2] Appearing among the items

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1. During the administrative proceedings, University argued that its practice of not referring Medicare accounts to Collections Limited was based upon its judgment that to do so would not be cost-effective. In part, University maintained that its experience had been that Medicare beneficiaries, who are necessarily 65 years of age or older, would have either made a payment or a promise to pay within the usual 120-day collection process. Older patients, University reasoned, were very concerned about their credit ratings and would not want their credit affected. Hence, further collection efforts would be fruitless.

University also presented evidence garnered from its collection activities in fiscal years 1989-1991. During those years, University referred *all* accounts to Collections Limited. Although a "nominal" increase in collections resulted, when the expense was deducted from the increase, University lost money each of those three fiscal years.

2. The Medicare program is administered through private companies who serve as fiscal intermediaries. Following the end of a fiscal year, providers must furnish the appropriate fiscal intermediary with a cost report that delineates the Medicare-related costs incurred by the provider in that fiscal year. The intermediary may audit the cost report, and if it determines that the provider has been overpaid by the Medicare program, it may issue a Notice of Program Reimbursement ("NPR"). A provider may appeal an NPR to the Provider Reimbursement Board ("PRO"), which may affirm or reverse the intermediary's decision. The PRB's action is reviewable by the Administrator of the Health Care Financing Administration, to whom the Secretary has delegated the power of review. If the right to review is exercised, the Administrators review decision becomes the Secretary's final determination, which is subject to judicial review.

on this cost report was a claim for "bad debt." Blue Cross conducted an audit of the 1986 cost report and determined that University's claim for bad debts, a sum of approximately $524,800, should be disallowed because University had failed to make a reasonable effort to collect the amount claimed. The Provider Reimbursement Board ("Board") unanimously reversed, finding that University's collection efforts were reasonable and that the Medicare bad debts claim was reimbursable. Electing to review the Board's determination, the Administrator of Health Care Financing Administration ("Administrator") reversed the Board and held that University's Medicare bad debt claim was properly disallowed. The crux of the Administrator's decision was University's practice of referring non-Medicare accounts only to Collections Limited. Indeed, the administrative record reveals that if after following its usual collection practices for 120 days, University had not referred any of its accounts to Collections Limited, this case would never have arisen. This decision represents the final decision of the Secretary.

After filing the underlying complaint seeking judicial review, University moved for summary judgment, arguing that the Secretary's decision is not entitled to great deference but is instead subject to "particular scrutiny" because the Administrator rejected the unanimous decision of the Board, because the decision is based upon an attempt to retroactively apply an unofficial interpretation of the governing regulation, and because the decision is inconsistent with the statutory mandate behind the Medicare law and it frustrates the policies Congress sought to implement; (2) that the Secretary's decision is not supported by Substantial evidence because its finding that University failed to use reasonable efforts to collect its Medicare accounts is not supported by substantial evidence;

and (3) that the Secretary is barred from challenging University's bad debt practices for fiscal year 1986 by the Omnibus Budget Reconciliation Act or 1987 ("OBRA of 1987"), § 4008(c). The Secretary responded in opposition to University's motion and filed its own motion for summary judgment, maintaining (1) that the Secretary's interpretation of the governing regulation is entitled to great deference; (2) that substantial evidence supports the Secretary's finding that University failed to use "reasonable efforts" to collect from Medicare beneficiaries; and (3) that § 4008(c) of OBRA of 1987 does not apply to this case.

II. DISCUSSION

A court should enter summary judgment in favor or a movant only if "there is no genuine issue as to any material fact and the moving party is entitled to a judgment as a matter of law." Fed. R. Civ. P. 56(c). The substantive law defines which facts are material. *Anderson v. Liberty Lobby, Inc.*, 477 U.S. 242, 248 (1986). "Only disputes over facts that might affect the outcome of the suit under the governing law will properly preclude the entry of summary judgment. Factual disputes that are irrelevant or unnecessary will not be counted. *Id.* When the decision of an administrative agency is under review, summary judgment is particularly appropriate since the relevant evidence has been thoroughly developed during the administrative process.

A. *Proper Standard of Review*

The Court must first decide what is the proper standard of review for the Secretary's final decision. Indubitably, an agency's decision may not be reversed unless it is "arbitrary,

capricious, an abuse of discretion, or otherwise not in accordance with law," or is "unsupported by substantial evidence." *See* 42 U.S.C. § 1395oo(f) (adopting the scope of review set out at 5 U.S.C. § 706); *Thomas Jefferson University v. Shalala*, 114 S. Ct. 2381, 2386-2387 (1994). Moreover, the Supreme Court has declared that when a challenge is based on the agency's interpretation of its own regulation, the reviewing court must give "substantial deference" to that interpretation. *Thomas Jefferson University*, 114 S. Ct. at 2386. The reviewing court may not substitute its judgment for the Secretary's with respect to what interpretation best serves the regulatory purpose. *Id.* The Secretary's interpretation "must be given controlling weight unless it is plainly erroneous or inconsistent with the regulation." *Id.* (citations and internal quotation marks omitted).

> In other words, [the court] must defer to the Secretary's interpretation unless an alternative reading is compelled by the regulation's plain language or by other indications of the Secretary's intent at the time of the regulation's promulgation This broad deference is all the more warranted when . . . the regulation concerns a complex and highly technical regulatory program, in which the identification and classification of relevant criteria necessarily require significant expertise and entail the exercise of judgment grounded in policy concerns.

Id. (citations and internal quotation marks omitted). Under *Thomas Jefferson University* it would appear that the Secretary's interpretation of the regulation at issue, 42 C.F.R. § 413.80(e), would be entitled to controlling weight unless it were determined that the plain language of § 413.80(e) or other inconsistency

compelled a different interpretation. However, the Court finds that in this case the Secretary's interpretation is not entitled to the measure of deference normally accorded an agency's interpretation of its own regulation. In short, *Thomas Jefferson University* does not control this case.

In *Thomas Jefferson University,* the Medicare provider sought reimbursement for costs it incurred in administering graduate medical education (GME) programs. For eighteen years, the provider never sought reimbursement for the cost of administering its GME programs, although for part of that period it claimed and was reimbursed for some GME related costs. In the nineteenth year, the provider included certain clerical cost associated with its GME programs.[3] Becoming more aggressive, in the twentieth year, the hospital included all direct and indirect administration costs in its GME program reimbursement claim. Following an audit, the fiscal intermediary disallowed all costs of administration. The Secretary's final decision adopted this ruling.

Thomas Jefferson University required the Supreme Court to construe 42 C.F.R. § 413.85(c).[4] The Secretary found that

3. As the Supreme Court noted, the fiscal intermediary allowed these clerical costs at first, but later determined that such allowance was in error. *Thomas Jefferson Univ.,* 114S. Ct. at 2385 n.2.

4. At issue in *Thomas Jefferson University* were two provisions of 42 C.F.R. § 413.85(c): (l) the "anti-distribution clause," which provided that while the Medicare program is "to share in the support of educational activities customarily or traditionally carried on by providers in conjunction with their operations, it is not intended to participate in increased costs resulting from redistribution of costs from educational institutions or units to patient care institutions or units[;]" and (2) the "community support" principle,'" which states that the costs of educational activities "should be borne by the community."

the part of § 413.85(c) called the "anti-redistribution clause" prohibited hospitals from shifting approved educational costs from an education unit to a patient care unit, even if the activities for which reimbursement is sought are the type traditionally engaged in by providers. The Secretary further found that the "community support principle" articulated in § 413.85(c) prohibited the reimbursement because it permitted community to improperly pass costs they have historically paid for along to the Medicare program. The Supreme Court held that the Secretary's interpretation of the regulation was valid because "it gives full effect to both clauses of the relevant sentence.' *Id.* at 2387.[5]

The case at bar is distinguishable from *Thomas Jefferson University.* There the Supreme Court dealt with an issue of *regulatory* construction. Here the parties disagree over the proper interpretation of the Provider Reimbursement Manual ("PRM"), which is nothing more than the Secretary's interpretation of 42 C.F.R. § 413.80(e). Moreover, whereas in *Thomas Jefferson University* the Secretary challenged the provider's claim shortly after it first sought reimbursement, the evidence in this case is undisputed that for years prior to 1986, University had been reimbursed for Medicare bad debt although it referred only non-Medicare accounts to its collection agency. Although it is true, as the Secretary maintains, that 42 C.F.R. § 413.8O(e) and the PRM were in place in 1586, it does not follow that *Thomas Jefferson University* requires the Court to defer to the Secretary's recently clarified interpretation of 42 C.F.R. § 413.80(e), especially when to do so would work an injustice to the provider.

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5. The Court further noted that "[t]he Secretary's reliance on a hospital's own historical cost allocations . . . is a simple and effective way of determining whether [the regulation has been complied with]." *Id.*

Appendix B

The parties' disagreement is not really over the text of the governing regulation, 42 C.F.R. § 413.80(e), which sets forth the criteria for bad debt reimbursement:

> (1) The debt must be related to covered services and derived from deductible and coinsurance amounts.
>
> (2) The provider must be able to establish that *reasonable collection efforts* were made.
>
> (3) The debt was actually *uncollectible* when claimed as worthless.
>
> (4) Sound business judgment established that there was no likelihood of recovery at any time in the future.

Id. (emphasis added). Rather, at issue in this case are two provisions of the PRM, a compilation of interpretive rules published by the Secretary to aid providers in determining when reimbursement is proper, that explicate the meaning of the phrases underscored above, "reasonable collection effort" and "uncollectible." With respect to the former, § 310 of the PRM provides in pertinent part as follows:

> To be considered a reasonable collection effort, a providers effort to collect Medicare deductible and coinsurance amounts must be similar to the effort the provider puts forth to collect comparable amounts from non-Medicare patients. . . .
>
> A. *Collection Agencies.* — A provider's collection efforts may include the use of a collection agency in addition to in lieu of subsequent billings, follow-

> up letters, telephone, and personal contacts. Where a collection agency is used, Medicare expects the provider to refer all uncollected patient charges of like amount to the agency without regard to class of patient. . . . Therefore, if a provider refers to a collection agency its uncollected non-Medicare patient charges which in amount are comparable to the individual Medicare deductible and coinsurance amounts due to the provider from its Medicare patients, Medicare requires the provider to also refer its uncollected Medicare deductible and coinsurance amounts to the collection agency.

As to "uncollectible," § 310.2 states that "[i]f after reasonable and customary attempts to collect a bill, the debt remains unpaid more than 120 days from the date the first bill is mailed to the beneficiary, the debt may be deemed uncollectible."

The Secretary argues that these two provisions read together clearly indicate that if a provider does not pursue additional collection efforts on any of its debts of a certain amount after 120 days, and the collection efforts during the first 120 days are otherwise reasonable, the collection efforts may be deemed reasonable and the debts may be presumed to be uncollectible. On the other hand, the Secretary reasons, if after 120 days of similar treatment, the provider refers non-Medicare debts but not Medicare debts of comparable size, the latter debts are not entitled to the presumption of non-collectibility. University counters that the Secretary's reading is "very selective and skewed" since it unduly emphasizes § 310 without properly accounting for the context. University argues that when read in context, §§ 310 and 310.2 permit a provider to treat Medicare debts differently from non-Medicare

debts if its collection efforts during the first 120 days are otherwise reasonable.

The Court finds that both parties are right — i.e., the PRM may be interpreted to both prohibit and allow providers to treat Medicare debts differently than non-Medicare debts. The problem is the PRM is just the Secretary's interpretation of the regulation, not the regulation itself, and this Court's role is not to determine for the Secretary what her own interpretation is. The one thing that is clear is that the PRM does not provide clear guidance for providers. This conclusion is buttressed by the fact that the Administrator was called upon to clarify the agency's "bad debt policy" in a 1990 memorandum ("1990 Memorandum"). The 1990 Memorandum clarified that if a provider refers its non-Medicare accounts but not its Medicare accounts to a collection agency, the Medicare accounts could not be claimed as a Medicare bad debt even after the passage of 120 days. (Admin. Rec. at 55-57.) However, the 1990 Memorandum acknowledges that §§ 310 and 310.2 of the PRM did not clearly establish the agency's bad debt policy and thus that clarification was needed:

> We believe that an intermediary could reasonably have interpreted the title of section 310.2, Presumption of Noncollectibility, to provide that an uncollectible account could be *presumed* to be a bad debt if the provider has made a reasonable and customary attempt to collect the bill for at least 120 days *even though* the claim has been referred to a collection agency.

(Admin. Rec. at 56.) The Secretary argues that the 1990 Memorandum and some of its recent decisions disallowing bad

debt claims are based upon the clarification of an already existing policy. The Court finds, however, that this policy did not exist in 1986.

Indeed, although the Secretary never reduced it to writing or otherwise reified it, in 1986 a policy existed that allowed University to refer non-Medicare accounts only to its in-house collection agency. The Secretary argues that the PRM and the regulation were in existence in 1986 and that in rendering her decision she was merely applying the law to the facts. However, it is undisputed that for many years before fiscal year 1986, University employed the same debt collection practices with respect to Medicare accounts and that it was always reimbursed for Medicare bad debts. Thus, when University submitted its cost report for fiscal year 1986 it was relying not merely on its interpretation of the PRM, but on the fact that for years prior thereto it had followed the same practice and had been reimbursed accordingly.

The Secretary's argument that no such policy existed because none had ever been specifically articulated is disingenuous. By the actions of her intermediary, the Secretary tacitly ratified University's debt collection practices. The Court finds that in 1986, when the collection efforts in question were made, the Secretary's policy allowed University to refer non-Medicare accounts only to a collection agency.

Having thus determined that the Secretary had a different policy in 1986, the question arises whether a final administrative decision that turns on the application of the new policy alters the measure of deference normally accorded an administrative decision. The Court finds that it does for a couple of reasons. First, the Secretary's change in policy has an unfair retroactive

effect. A legislative or administrative change that is retroactive in application raises a red flag; statutes and regulations are not construed to operate retroactively unless such a construction is compelled by their language. *Bowen v. Georgetown University Hosp.*, 488 U.S. 204, 208 (1988). Retroactivity is not favored in part because "'[t]he power to require readjustments for the past is drastic. *Cf. id.* (quoting *Brimstone R. Co. v. United States*, 276 U.S. 104, 122 (1928)). Although *Georgetown University Hospital* dealt with the Secretary's power to promulgate retroactive regulations, it indicates that a charge in policy — even if it involves interpretive rules — which has an unfair retroactive effect exposes the Secretary's decision to heightened scrutiny. *See also St. John's Hickey Memorial Hosp. v. Califano*, 599 F.2d 803 (7th Cir. 1979) (holding that retroactive effect of a change in agency's policy means decision is not entitled to usual measure of deference).

In *St. John's — Hospital*, the provider's claim for reimbursement for fiscal year 1974 was denied by the intermediary on the basis of a change in policy adopted in 1975. The Seventh Circuit found that "[p]rocedural inadequacies surrounding the administrative decision deprive it of any presumption of correctness to which it otherwise might be entitled." *Id.* at 814. It based its holding on the agency's failure to publish its policy in the Federal Register, as required by 5 U.S.C. § 552(a)(1)(D). *Id.* The court noted that if such a policy or interpretation is not so published, "a person without actual notice of it 'may not in any manner . . . be adversely affected' by it." *Id.* (quoting 5 U.S.C. §552(a)(1)(E)). The policy was never published and the provider had no notice of it until denied reimbursement. *Id.*

The *St. John's — Hospital* court was concerned with the fairness of the agency's retroactive application of policy,

particularly the reliance placed on the intermediary's interpretation. "[The agency] must have been aware that providers would make business decisions in reliance on the interpretation of the regulations by the intermediaries . . .

The failure to inform the intermediaries of the new policy so that they could render correct advice and to publish the policy for the benefit of the providers is inexcusable." *Id.* The court found that holding the agency's feet to the fire was healthy: "First, affected parties will be put on notice of the agency's intended course. Second, and more important, either of those procedures assures that some party with a stake in the policy will be enabled to present its views to the agency before the policy becomes entrenched by repeated application." *Id.*

The Court finds *St John's — Hospital* highly persuasive. The reasons articulated therein for according less than the usual measure of deference to the Secretary's decision are amplified here. To its detriment, University relied upon a course of dealing established over many years that amounted to a policy. For years, Blue Cross had accepted University's debt collection practices and had regularly approved payment for its Medicare bad debt claim. Perhaps the recent "clarification" is a tacit acknowledgement of administrative failure. To allow the Secretary's final decision to stand would be unduly harsh, since it would force University to absorb a loss of $524,800. The Court cannot countenance this result.

The Court finds that the Secretary is estopped from applying the clarified rule to fiscal year 1986. *See Heckler v. Community Health,* 467 U.S. 51, 61-63 (3g84) (holding that when a private party is deprived of something to which it was entitled of right, it has suffered a detrimental change in its position that will justify

estoppel); *Alacare Home Health Services. Inc. v. Sullivan*, 891 F.2d 850, 855 (11th Cir. 1990) (citing *Community Health*). Although the private party in *Community Health* did not persuade the Supreme Court that the facts of the case justified estoppel, the case at bar comprises facts that do. In *Community Health*, the private party relied upon the intermediary to claim what amounted to an improper double reimbursement. The Court found that since the private party never had a right to part of that double reimbursement, the government was not subject to estoppel. *See Community Health*, 467 U.S. at 61-63. Here, however, following fiscal year 1986, University had a right to reimbursement for Medicare bad debts. Nothing in the Secretary's clarified policy prevents University from receiving reimbursement for uncollectible Medicare bad debts after referring those debts to Collections Limited. University was able to do that in fiscal years 1989-1991 because it knew that was how the Secretary was interpreting 42 C.F.R. § 413.80(e). with respect to fiscal year 1986, however, University cannot comply with the clarified interpretive rule and hence would lose $524,800. If the Secretary were to prevail here, University would have forever lost its right to reimbursement for fiscal year 1986, even though it was relying to its detriment on the Secretary's practice of reimbursing it for Medicare bad debt during several years prior to 1986. Under these circumstances, estoppel is appropriate.

The Secretary argues that she may rely on adjudication to develop the governing rules. The APA does not require that all specific applications of a rule evolve by further, more precise rules rather than by adjudication. *Shalala v. Guernsey Memorial Hosp.*, 115 S. Ct. 1232, 1237 (1995). However, *Guernsey* dealt with *regulations* that were "comprehensive and intricate in detail." *Id.* Under those circumstances, adjudication was a proper

mode for the Secretary's rulemaking authority. *Id.* However, in the instant case, the regulation is anything but "comprehensive and intricate in detail," and the Secretary's interpretive rules do not clearly spell out for providers what they should do. Indeed, the Secretary's argument that there was not a policy of permitting the practice at issue is belied by the facts of this case, which clearly show that her intermediaries allowed such practices for years.

The Court expresses no view as to whether the Secretary's interpretation, when properly articulated, published, and applied, is entitled to the usual measure of deference.[6] But when an agency alters its interpretive rules, even under the guise of "clarification," and in a decision applies that clarified rule in a manner that causes a harsh and unfair impact, that decision is not entitled to the "substantial deference" principle set out in *Thomas Jefferson University.* The Secretary's decision having been founded upon an unfair application of the clarified policy, the Court finds that the Secretary's final decision cannot be supported by substantial evidence

B. *Legislative Moratorium*

Alternatively, the Court finds that the Secretary's decision is not supported by substantial evidence because the Secretary is estopped by the Omnibus Budget Reconciliation Act of 1987

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6. Under *Thomas Jefferson University,* an agency's interpretation of its own regulation is entitled to "substantial deference." *Thomas Jefferson University,* 114 S. Ct. at 2386. The Secretary's interpretation "must be given controlling weight unless it is plainly erroneous or inconsistent with the regulation." *Id.* (citations and internal quotation marks omitted).

("OBRA of 1987"), § 4008(c),[7] from denying University's claim for Medicare "bad debt" reimbursement for fiscal year 1986. OBRA of 1987 and its amendments impose a moratorium on changes in policy as to reimbursements for Medicare "bad debts":

> In making payments to hospitals under title XVIII of the Social Security Act, the Secretary of Health and Human Services shall not make any change in the policy in effect on August 1, 1987, with respect to payment under title XVIII of the Social Security Act to providers of service for reasonable costs relating to unrecovered costs associated with unpaid deductible and coinsurance amounts incurred under such title (including criteria for what constitutes a reasonable collection effort, including criteria for indigency determination procecures, for record keeping, and for determining whether to refer a claim to an external collection agency).
>
> The Secretary may not require a hospital to change its bad debt collection policy if a fiscal intermediary, in accordance with the rules in effect as of August 1, 1987, with respect to criteria for indigency determination procedures, record keeping, and determining whether to refer a claim to an external collection agency, has accepted such policy before that date, and the Secretary may not collect from

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7. Following its enactment, § 4008(c) of OBRA of 1987 was amended twice. *See Technical and Miscellaneous Revenue Act of 1988*, Pub. L. No. 100-647, § 8402, and *Omnibus Reconciliation Act of 1989*, Pub. L. No. 101-239, § 6023. The version of § 4008(c) quoted herein incorporates these amendments.

> the hospital on the basis of an expectation of a change in the hospital's collection policy.

Id. Under § 4008(c) of OBRA of 1987, the Secretary is prohibited from forcing University to change its bad debt collection policy — including its criteria for determining whether to refer a claim to an external collection agency — if Blue Cross accepted that policy before August 1, 1987. The Court finds that Blue Cross did accept University's bad debt collection policy before the operative date and that the § 4008(c) moratorium applies.

A recent decision of the Southern District of Texas, *Harris County Hospital District v. Shalala,* 863 F. Supp. 404 (S.D. Tex. 1994), which University cited, is especially persuasive. *Harris County Hospital* arose from the Secretary's denial of the hospital's 1988 fiscal year claim for bad debt reimbursement. The Secretary's decision was based upon the provider's failure to incorporate an asset test into its criteria for determining indigence. The provider used an income test, but had never used an asset test. However, for all years before 1988, the fiscal year in question, the intermediary, Blue Cross and Blue Shield of Texas, had accepted the provider's indigence determinations and had reimbursed the provider accordingly. The Texas court held that the Secretary could not require the provider to change the way it determines indigence since the intermediary had accepted that method before August 1, 1987. *Id.* at 409. The underpinning of the court's holding was its finding that Blue Cross had clearly accepted the hospital's policy by its course of conduct in the years prior to 1988: "For years Blue Cross accepted the [hospital]'s policy and paid full reimbursements for the claims." *Id.*

Appendix B

In the case at bar, the Court finds that before August 1, 1987, Blue Cross and Blue Shield of Georgia accepted University's method of determining what constitutes a reasonable collection effort, including its criteria for determining whether to refer a claim to an external collection agency. Before the 1986 cost report, Blue Cross had always accepted University's bad debt collection claims, determined under the policy now contested. As in *Harris County,* its acceptance can be inferred from its actions; Blue Cross did not have to expressly declare its acceptance.

The Court is not persuaded by the Secretary's arguments to the contrary, which are essentially the same arguments raised in *Harris County.* Relying in part on the MCFA Administrator's decision in *Bradford Hospital,* 736 Medicare & Medicaid Guide (CCH) ¶ 41,062 (Nov. 24, 1992), the Secretary argues that the moratorium does not apply because University's collection efforts did not comply with the rules in effect during 1986, by which she means § 310 of the PRM. This argument is vulnerable in several ways. First, as the *Harris County* court noted,

> the last sentence of § 4008(c) states "that if the intermediary (Blue Cross) has accepted, in accordance with the rules in effect on August 1, 1987, the hospital's bad debt collection policy, the Secretary cannot require the hospital to change it. The Secretary wants it to say that she cannot force a hospital to change the policy only if the policy is in accord with the rules. If the policy is not, then she can. That would leave nothing to the moratorium. The phrase 'in accordance with the rules in effect on August 1, 1987' modifies 'accepted,' not 'policy.' "

Id. at 408-409. Second, the rule on which the Secretary relies, PRM § 310, is merely interpretive. "The rules in the [PRM] do not have the effect of substantive law or regulation, rather they are interpretive rules." *Id.* at 409 (citations omitted). Finally, the Court has determined already that in 1986 the Secretary's unarticulated policy permitted University to refer non-Medicare debts only to its in-house collection agency and that this policy was consistent with §§ 310 and 310.2 of the PRM. The Secretary's arguments are unavailing. Therefore, the moratorium of § 4008(c) of OBRA-1987 prevents the Secretary from denying University's Medicare bad debt reimbursement claim for fiscal year 1986.

III. CONCLUSION

There are no genuine issues of material fact and University is entitled to judgment as a matter of law since the Secretary's decision is not supported by substantial evidence because that decision was based upon an unfair application of a recently clarified policy and because the moratorium of the Omnibus Budget Reconciliation Act of 1987, § 4008(c), estops the Secretary from denying the Medicare bad debt claim at issue. Accordingly, University's Motion for Summary Judgment is GRANTED and the Secretary's Motion for Summary Judgment is DENIED.

SO ORDERED this 28th day of September, 1995, at Augusta, Georgia.

DUDLEY H. BOWEN, JR.
UNITED STATES DISTRICT JUDGE

Appendix B

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF GEORGIA

CASE NUMBER: CV103-180

UNIVERSITY HEALTH SERVICES, INC.

v.

DONNA E. SHALALA, Secretary of Health and Human Services

JUDGMENT IN A CIVIL CASE

* * *

☑ Decision by Court. This action came on for consideration before the Court. The issues have been considered and a decision has been rendered.

IT IS ORDERED AND ADJUDGED that in accordance with the Order of this Court entered September 28, 1995, granting the motion for summary judgment by plaintiff, JUDGMENT IS HEREBY ENTERED in favor of the plaintiff.

September 28, 1995	HENRY R. CRUMLEY, JR.
Date	*Clerk*
	s/ illegible
	(By) Deputy Clerk

APPENDIX C — DECISION OF THE ADMINISTRATOR OF THE HEALTH CARE FINANCING ADMINISTRATION DATED JULY 9, 1993

HEALTH CARE FINANCING ADMINISTRATION

Decision of the Administrator

In the Case of:

UNIVERSITY HOSPITAL,

Provider

vs.

BLUE CROSS AND BLUE SHIELD ASSOCIATION/BLUE CROSS AND BLUE SHIELD OF GEORGIA,

Intermediary

Claim for:

Provider Cost Reimbursement Determination of Reasonable Costs for Cost Reporting Period(s) Ending December 28, 1986

Review of:

PRRB Decision No. 93-D55
Dated: July 9, 1993

This case is before the Administrator, Health Care Financing Administration (HCFA), for review of the decision entered by the Provider Reimbursement Review Board (the Board) on July 9, 1993. The review is during the 60-day period in section

1878(f)(1) of the Social Security Act (the Act), as amended [42 USC 139500(f)]. The Intermediary and HCFA's Bureau of Policy Development (BPD) submitted comments requesting that the Administrator reverse the Board's decision. The Provider submitted comments requesting that the Administrator decline to review the Board's decision. The parties thereafter were notified of the Administrator's intention to review the Board's decision in this case. Additional comments were received from the Provider. Accordingly, the case is now before the Administrator.

ISSUE AND BOARD'S DECISION

The issue concerns whether the Intermediary's adjustment disallowing Medicare bad debts claimed by the Provider was proper. Specifically, the issue is whether the Provider made reasonable efforts to collect bad debts incurred for deductibles and coinsurance due from Medicare beneficiaries under 42 C.F.R. § 413.80.

The Board held that the Intermediary's adjustment was not proper. The Board found that the Provider made the same effort to collect its Medicare and non-Medicare accounts for 120 days and thereafter sent only its non-Medicare accounts to its in-house collection agency. Relying on previous decisions, the Board stated that to be reimbursed for its Medicare bad debts, the Provider was required to provide, and did provide, a valid reason for not sending its unpaid Medicare accounts to the collection agency. The Board found that the valid reason was based on sound business judgment and that the Provider introduced substantial evidence to support this decision. Specifically, the Board found evidence in the record that the Provider had sufficient knowledge of the Medicare population

in its community to assess the unlikelihood of collecting its outstanding Medicare accounts.[1] Further, the Board relied on evidence that the Provider presented showing that it incurred losses in subsequent cost years when it sent its Medicare accounts to the collection agency.

In addition, the Board rejected the Intermediary's argument that the Provider Reimbursement Manual (PRM) (HCFA Pub. 15-1) section 310, requiring a provider who uses a collection agency to refer all uncollected patient charges of like amount to the agency without regard to the Medicare or non-Medicare status of the patient, does not contain an exception for cost effectiveness. The Board also noted that "one of the regulatory criteria for a Provider to meet before bad debts may be claimed permits a Provider to use 'sound business judgement' regarding the likelihood of recovery, as found in 42 C.F.R. § 413.80(e)(4)."

SUMMARY OF COMMENTS

The Intermediary commented that the Board's decision directly contradicts the Medicare program instruction found in PRM section 310. The manual section establishes that, where a Provider uses a collection agency, it must refer all uncollected patient charges to the agency without regard to the class (i.e., Medicare or non-Medicare status) of patient. Therefore, the Intermediary requested the Administrator to reverse the Board's decision.

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1. The Board noted that the Provider relied on the following factors in making its assessment: 1) a high percentage of Medicare accounts was collected in the first 120 days of the collection period; 2) staff knowledge of the elderly community and the concern of the elderly with credit ratings; and 3) assessments of collection personnel who analyzed the Medicare accounts.

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The Provider commented that the Board's decision complies with applicable statutes, regulations and other authority and is supported by substantial evidence. Further, HCFA's and the Intermediary's interpretation of the issue in controversy would require the Provider to engage in conduct resulting in a financial loss and is arbitrary, capricious and contrary to law. The Provider stated that it made a reasonable effort to collect its Medicare accounts insofar as it: 1) assessed the collectibility of Medicare and non-Medicare accounts in the same way; 2) made a reasonable business judgment regarding the collectibility of the Medicare accounts; 3) collected a high percentage of the Medicare accounts; and 4) empirically proved that further pursuit of Medicare accounts would not be cost-effective.

The Provider additionally stated that the PRM, upon which the Intermediary relies, does not have the force and effect of law and cannot supersede the applicable regulations. The Provider also commented that its efforts to collect its Medicare bad debts conformed with the "reasonableness standard" which "pervades the entire Medicare program," citing sections of the Act and regulations. "Reasonable," the Provider commented, "means rational, equitable, moderate, and fair." Further, that the Provider referred its Medicare accounts to its in-house collections agency in subsequent cost years is not evidence that the Provider admits that HCFA's position is valid.

BPD commented that the Board's decision contravenes section 413.80(e)(2) of the Medicare regulations and PRM section 310. The regulation states that, before Medicare will pay for bad debts, a Provider must establish that reasonable collection efforts were made to recover the accounts. Defining "reasonable collection efforts," the manual establishes that a Provider must exert a similar effort to collect unpaid accounts from Medicare

and non-Medicare patients. The manual states that if a Provider uses a collection agency, it must refer all uncollected charges of like amount to the agency, without regard to the class of patient. The requirement is not limited to any particular stage of the collection process.

BPD stated that in the immediate matter, the Provider made similar collection efforts for its Medicare and non-Medicare accounts for at least 120 days. However, the Provider then sent its outstanding non-Medicare accounts to its in-house collection agency but did not similarly send its Medicare accounts to the agency. BPD stated that, for the Provider to have met the requirements of the regulation and manual, it would have had to send its Medicare accounts to the in-house collection agency. Finally, BPD referred the Administrator to a June 11, 1990 HCFA memorandum reiterating that if a Provider refers its non-Medicare accounts to a collection agency, but does not refer its Medicare accounts, the Medicare accounts cannot be claimed as Medicare bad debts even after the passage of 120 days.

DISCUSSION AND EVALUATION

The entire record which was furnished by the Provider Reimbursement Review Board has been examined, including all correspondence, position papers, and exhibits. The Board's decision has been reviewed by the Administrator. All timely comments received after entry of the Board's decision have been made a part of the record and have been considered.

Section 1861(v) (1)(A) of the Social Security Act requires that providers of services to Medicare beneficiaries are to be reimbursed the reasonable cost of those services. Reasonable cost is defined by that section as "the cost actually incurred,

excluding therefrom part of the incurred cost found to be unnecessary in the *efficient delivery* of needed health services, and shall be determined in accordance with regulations establishing the method or methods to be used, and the items to be included. . . ." Section 1861(v)(1)(A) does not specifically address the determination of reasonable cost, but authorizes the Secretary to promulgate regulations and principles to be applied in determining reasonable cost. One of the underlying principles set forth in the Act is that Medicare shall not pay for costs incurred by non-Medicare beneficiaries, and vice-versa, i.e., Medicare prohibits cross-subsidization of costs.

The foregoing principles are reflected and further explained in the Medicare regulations. The regulations establish at 42 C.F.R. § 413.9(c) that the determination of reasonable cost must be based on costs related to the care of Medicare beneficiaries. If the Provider's costs include amounts not related to patient care, or costs that are specifically not reimbursable under the program, those costs will not be paid by the Medicare program.

The regulations specifically provide at 42 C.F.R. § 413.80(a) that bad debts are reductions in revenues and are not included in allowable costs. However, section 413.80(a) further provides that bad debts attributable to the deductible and coinsurance amounts of Medicare beneficiaries are reimbursed under the Medicare program.[2] Bad debts are defined at 413.80(b)(1) as:

> amounts considered to be uncollectible from accounts and notes receivable that were created or acquired in providing services. "Accounts receivable" and "notes receivable" are designations for claims arising from the furnishing of services,

2. *See also* Section 304 of the PRM.

> and are collectible in money in the relatively near future.

Section 413.80(d) of the regulations states that payment for deductibles and coinsurance amounts are the responsibility of the beneficiaries. However, recognizing the reasonable costs principle of section 1861(v)(1)(A) of the Act, prohibiting cross-subsidization, the program acknowledges that the inability of Providers to collect deductibles and coinsurance amounts from the Medicare beneficiaries could result in part of the costs of Medicare covered services being borne by individuals who are not beneficiaries. To prevent such cross-subsidization, Medicare pays Providers for allowable bad debts.[3]

Thus, 42 CFR 413.80(e) sets forth the criteria that must be met before Medicare will pay for claimed bad debts. To be allowable, a bad debt must meet the following criteria:

> (1) The debt must be related to covered services and derived from deductible and coinsurance amounts.
>
> (2) The provider must be able to establish that *reasonable collection efforts* were made.
>
> (3) The debt was actually uncollectible when claimed as worthless.

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3. *See* 42 C.F.R. § 413.80(d). The Administrator notes that, for the cost year at issue, the Provider was paid by Medicare for its inpatient operating costs prospectively on a per discharge basis, pursuant to the Medicare Prospective Payment System (PPS). *See* section 1886 of the Act; 42 C.F.R. Part 412. However, Medicare pays for bad debts separate from PPS on the basis of reasonable cost. *See* 42 C.F.R. §§ 412.2(e)(3), 412.115(a), 413.80.

> (4) Sound business judgment established that there was no likelihood of recovery at any time in the future.
> (Emphasis added.)

As noted above, the issue presented in the immediate matter involves the second criterion of section 413.80(e), whether the Provider established that it made reasonable collection efforts with respect to its claimed Medicare bad debts.

The reasonable collection effort requirement of section 413.80(e)(2) is explained in section 310 of the PRM. HCFA states in the PRM:

> To be considered a reasonable collection effort, a Provider's effort to collect Medicare deductible and coinsurance amounts must be similar to the effort the Provider puts forth to collect comparable amounts from non-Medicare patients. . . .
>
> A. *Collection Agencies.* — A Provider's collection effort may include the use of a collection agency in addition to or in lieu of subsequent billings, follow-up letters, telephone, and personal contacts. *Where a collection agency is used. Medicare expects the Provider to refer all uncollected patient charges of like amount to the agency without regard to class of patient.* . . . Therefore, if a Provider refers to a collection agency its uncollected non-Medicare patient charges which in amount are comparable to the individual Medicare deductible and coinsurance amounts due the Provider from its Medicare patients, Medicare requires the Provider to also refer

> its uncollected Medicare deductible and coinsurance amounts to the collection agency.

Additionally, within the context of the definition of the term, reasonable collection effort, section 310.2 of the PRM establishes a 120-day "presumption of noncollectibility":

> If after reasonable and customary attempts to collect a bill, the debt remains unpaid more than *120 days from the date the first bill is mailed to the beneficiary*, the debt *may be* deemed uncollectible. (Emphasis added.)

Further, section 4008(c) of the Omnibus Budget Reconciliation Act (OBRA) of 1987[4] prohibited the Secretary from making any changes in policies that were in effect on August 1, 1987, regarding reimbursement of bad debts, including the criteria of what constitutes a bad debt. Subsequently, this provision was amended by section 8402 of the Technical and Miscellaneous Revenue Act of 1988[5] and section 6023 of the OBRA of 1989,[6] to provide that:

> The Secretary may not require a hospital to change its bad debt collection policy if a fiscal intermediary, *in accordance with the rules in effect as of August 1, 1987*, with respect to criteria for indigency determination procedures, record keeping, and

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4. Pub. Law 100-203.

5. Pub. Law 100-647.

6. Pub. Law 101-239.

> determining whether to refer a claim to an external collection agency, has accepted such policy before that date, and the Secretary may not collect from the hospital on the basis of an expectation of a change in the hospital's collection policy. (Emphasis added.)

Additionally, an agency memorandum, dated June 11, 1990, clarified the intent of the regulation, the PRM and the effects of the moratorium on the allowance of bad debts. Specifically, the memorandum states:

> [U]ntil a Provider's reasonable collection effort has been completed, *including both in-house efforts and the use of a collection effort*, a Medicare bad debt may not be reimbursed as uncollectible. This is in accord with the fourth criterion in section 308 which provides that an uncollected Medicare account cannot be considered an allowable Medicare bad debt unless sound business judgment established that there is no likelihood of recovery at any time in the future. We have always believed that, clearly, *there is a likelihood of recovery for an account sent to a collection agency* and that claiming of a Medicare bad debt at the point of sending the account to the agency would be contrary to the bad debt policy in sections 308 and 310. Therefore, in accordance with our position, when [HCFA] had been informed of such situations, [HCFA] had advised regional offices and others that a *bad debt could not be claimed while an account is at the collection agency.* (Emphasis added.)

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Finally, with regard to the moratorium, the agency specifically discussed the limited application of the moratorium in the context of section 310.2, i.e., the presumption of non-collectibility after 120 days, stating that:

> We believe that an intermediary could have reasonably interpreted the title of section 310.2, Presumption of Noncollectibility, to provide that an uncollectible account could be *presumed* to be a bad debt of the Provider if the Provider has made a reasonable and customary attempt to collect the bill for at least 120 days e*ven though* the claim had been referred to a collection agency. . . . As noted above, section 310.2 provides that the debt may be deemed uncollectible rather than that the debt "shall" or "must" be deemed uncollectible. On the contrary, "may" denotes the existence of discretion. Therefore, where an intermediary, in accordance with the preceding paragraph, applied section 310.2 to permit an allowable Medicare bad debt for an account sent to a collection agency, consistent with the Provider's procedures for non-Medicare patients, the moratorium would prohibit the intermediary from applying the policy differently despite HCFA directives to the contrary dated subsequent to August 1, 1987.

The agency memorandum further states that:

> Finally, we believe that it is important to emphasize that, generally, the bad debt policy is otherwise unaffected by the above discussion . . . *[I]f a provider refers its non-Medicare accounts but not*

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> *Medicare accounts to a collection agency. The Medicare accounts could not be claimed as a Medicare bad debt even after the passage of 120 days.* (Emphasis added.)

The record in this case reveals that the Provider pursued comparable in-house collection efforts for all accounts, both Medicare and non-Medicare, for at least 120 days. The collection efforts included billing, subsequent billing, sending letters, and making telephone and personal contacts. At the end of the 120-day period, the Provider wrote or charged off as bad debts all outstanding accounts, both Medicare and non-Medicare. Thereafter, the Provider forwarded the non-Medicare accounts to its in-house collection agency, but forwarded none of the Medicare accounts to the agency.

Applying the above-cited sections of the Act, regulations, manual, and agency memoranda to the facts presented in the record, the Administrator finds that the Intermediary properly determined that the bad debts claimed by the Provider may not be paid by Medicare. The Intermediary's adjustment, based on the Provider's failure to comply with the provisions of section 310.A of the PRM, is supported by the record and is consistent with section 413.80(e) of the Medicare regulations. The Administrator finds that the plain language of the manual, in accordance with the reasonable collection effort requirement of the regulation, establishes that when a Provider sends its non-Medicare accounts to a collection agency, it must also send its Medicare accounts of like amount to the agency in order to properly claim the bad debts for Medicare payment purposes. As occurred in the immediate matter, where a Provider fails to pursue its Medicare and non-Medicare accounts similarly, the Provider has not engaged in reasonable collection efforts to

recover its Medicare bad debts as required under 42 C.F.R. § 413.80(e)(2).

Further, the Administrator finds that section 310.A of the PRM, as applied in this instance, is entirely consistent with the objectives and purposes of the regulation at 42 C.F.R. § 413.80(e). The manual reflects that reasonable collection efforts can be determined by the manner in which the Provider pursues the collection of debts for which it does not have a guarantor.[7] Thus, section 310.A logically requires that, in instances in which a collection agency is used, the Provider should refer all uncollected patient charges of like amount to the agency without regard to class of patient. Therefore, Medicare accounts of comparable amounts, under the criteria of Section 310.A, are not properly claimed as worthless if the Provider fails to use similar collection efforts for Medicare and non-Medicare accounts.

In addition, the Administrator acknowledges that the parties in this case stipulated that the Provider pursued a genuine, rather than token, in-house collection effort during the first 120 days of the collection period and that during this period the Medicare and non-Medicare accounts were pursued similarly; the Provider relied on this stipulation to support its argument that it engaged in reasonable collection efforts to recover its Medicare bad debts. The Administrator recognizes that if a debt remains unpaid more

7. The courts have recognized generally an advantage which a Provider has when the Federal government, rather than a private individual, is the debtor. *See Mount Sinai Hospital of Greater Miami v. Weinberger*, 517 F. 2d 329, 335 (5th Cir. 1975) (involving appeal rights with respect to noncovered services). With respect to unpaid Medicare accounts, the Medicare program is the debtor only after reasonable collection efforts have been made with regard to the Medicare beneficiary.

than 120 days from the date the first bill is mailed to the beneficiary, the debt may be deemed uncollectible, as established at PRM section 310.2. As noted previously, however, section 310.2 implies discretionary rather than mandatory application of the presumption, providing that the debt "may" — not "shall" — be deemed uncollectible. More importantly, section 310.2 only applies where a Provider has otherwise engaged in reasonable collection efforts. Thus, as noted in the agency's June 1, 1990 memorandum, *supra,* section 310.2 cannot supersede the separate requirement of section 310.A.

The Administrator further notes that the Board found that the Provider may be excepted from the reasonable collection effort requirement of section 310.A of the PRM if it can establish a valid reason, based upon sound business judgment, for not sending its Medicare accounts for further collection when it sends its non-Medicare accounts of like amount to the agency.[8] The Board stated that the record supported the Provider's decision not to refer the Medicare claims for further collection.

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8. Similarly, the Provider asserted that, based on the Administrator's decision in *Bradford County Hospital v. Blue Cross and Blue Shield Association and Blue Cross and Blue Shield of Florida*, Decision No. 92-D72, the Administrator should apply the following "test" in the immediate matter: a Provider complies with the reasonable collection effort requirement of 42 C.F.R. § 413.80(e) when it refers only non-Medicare accounts to an outside collection agency after a genuine in-house collection effort of at least 120 days *if* it can supply evidence of the initial reason for the policy. The Administrator notes, however, that the *Bradford* holding does not create such a test. As in this case, the Administrator held in *Bradford* that the Provider had not made a reasonable effort to collect its Medicare bad debts, as required under 42 C.F.R. § 413.80(e)(2), where it had sent its non-Medicare accounts to a collection agency and did not send its Medicare accounts of like amount to the agency.

Further, the Board wrote that it considered most important certain evidence presented by the Provider concerning the cost effectiveness of processing Medicare accounts through the in-house collection agency in 1989, 1990 and 1991. That evidence, the Board held, validated the Provider's earlier decision.

The Administrator finds, however, that the record does not support the Board's holding that the Provider adequately justified its decision not to refer its Medicare accounts to the collection agency.[9] The record reveals that, for the cost year at issue, the Provider based its decision not to treat similarly the Medicare and non-Medicare accounts on: 1) historical evidence showing that the Provider was more successful in collecting amounts due from Medicare accounts than from non-Medicare accounts[10]; and 2) a generalized perception that the Medicare patients would likely either pay their deductible and coinsurance obligations during the initial 120-day collection period or would not be inclined or able to pay.[11]

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9. Thus, the Administrator finds the Board's reliance upon the earlier decisions in *Reed City Hospital v. Blue Cross and Blue Shield Association Blue Cross and Blue Shield of Michigan*, PRRB Decision No. 86-D67; and *St. Francis Hospital and Medical Center v. Blue Cross and Blue Shield Association/Kansas Hospital Service Association*, PRRB Decision No. 86-D21, which are factually distinguishable, is misplaced. Further, the Administrator notes that Board decisions are not precedential.

10. The statistics indicated that the Provider was more successful at collecting Medicare accounts than non-Medicare accounts during the initial collection period. Additional evidence reflected that the Provider collected a higher percentage of its Medicare accounts than its non-Medicare accounts overall, even though only non-Medicare accounts were sent to the in-house collection agency.

11. With respect to the Provider's perception of its patient

(Cont'd)

With respect to the historical evidence comparing Medicare and non-Medicare accounts collection results, the Administrator notes that such evidence does not support the proposition that further pursuit of the Medicare accounts would be ineffective as compared to further pursuit of the non-Medicare accounts. In addition, with respect to the Provider's conclusions regarding the payment behavior of its Medicare patient population, the Administrator notes that the only evidence introduced by the Provider was testimony that: 1) the Provider was familiar with its patient population because it had served the community for 174 years; and 2) contacts with Medicare patients during the initial 120-day collection process led the Provider to believe that further pursuit of the accounts would not result in recovery.[12] The Administrator finds that this evidence reveals that the rationale underlying the Provider's decision not to send the Medicare accounts to the in-house collection agency was largely speculative. In sum, the evidence does not adequately

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(Cont'd)
population, the Provider stated that, because it was an integral part of the community, it was capable of judging that:

> (1) members of [its] community desire to avoid bad credit rating, such that the Medicare patients who have the assets to pay their accounts will do so or arrange to do so within the extensive 120 day collections process, and (2) because the Medicare patients who are able to pay will have done so by the end of the 120 day process, further collection efforts on these accounts will not yield significant results and in fact will lose money for the Provider. *See* Provider's Post-Hearing Brief, pp. 2, 22-23.

12. *See* Transcript of December 2, 1992 Hearing ("Transcript"), pp. 24-25, 30-31, 55.

substantiate the Provider's claim that it was justified in its dissimilar treatment of Medicare and non-Medicare accounts.

Further, while the Board found that evidence regarding the Provider's collection efforts from the 1989-1991 fiscal years validated the Provider's decision to handle its 1986 cost year accounts dissimilarly, the Administrator finds the subsequent cost year information not relevant in this instance. While the Provider submitted evidence regarding the collection agency's processing costs per account in the later years, it did not furnish such evidence for the cost year in dispute to show that the costs were, in fact, comparable.[13] Moreover, the record reveals that, following the cost year at issue, The staffing and computer systems of the in-house collection agency significantly changed.[14] Consequently, any comparison of the differing systems and operations cannot be relied on to sustain the Provider's position. Therefore, the Administrator finds the Board's reliance on the subsequent cost year information misplaced: the evidence does not sufficiently show that the collection agency's expenses for the cost year at issue and the subsequent years were comparable.[15]

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13. *See* Transcript, p. 32.

14. *See* Provider Exhibits 19, 20; Provider's Post-Hearing Position Paper, pp. 9-11.

15. The Provider offered testimony at the hearing that it was necessary to increase the in-house collection agency staff and computer capacity in 1989 and 1990, due to the referral of the Medicare accounts to the collection agency beginning in 1989. The Provider's witness stated that similar increases in capacity likely would have been required earlier had the referral of the Medicare accounts taken place earlier. (*See* transcript, pp. 33, 36-40.) (The

(Cont'd)

Finally, the Administrator notes that the Board did not rule on the question whether the claimed bad debts should be allowed on the basis of the moratorium on adjustment of Medicare bad debt costs established by OBRA of 1987, as amended. The moratorium, as noted above, established that the Secretary may not compel a hospital to change its bad debt collection process if its intermediary accepted the policy in the past, so long as the policy complied with the rules in effect as of August 1, 1987. The Secretary has determined, however, that the Provider's collection efforts did not comply with the rules in effect during the cost year at issue, which remained in effect as of August 1,

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(Cont'd)
Provider later stated in its post-hearing papers that "the need for increases in capacity were (sic) caused *at least in part* by the referral of Medicare accounts to [the collections agency]." (Emphasis added.) (Provider's Post-Hearing Brief, p. 10.) Similarly, Provider Exhibit 20 states that the computer system software used in 1986 would have required "extensive modifications" to handle the separation of Medicare bad debt monies from other monies.

However, the Provider acknowledged post-hearing that, while the software of the old system would have required modification, the raw capacity of the computer system used in 1986 for processing accounts was "theoretically unlimited." (*See* Provider's Post-Hearing Brief, p.10.) Further, the Provider testified that in 1989 it placed 45,419 non-Medicare accounts, and only 2,297 Medicare accounts, with the agency; in 1990, less than three percent of the total billings of the collection agency represented Medicare accounts. Nevertheless, the Provider's witness stated, it was the addition of the Medicare accounts that required an increase in processing capacity. (*See* Transcript, pp. 38-42, 61.) Based on this conflicting evidence, the Administrator finds that the Provider has not adequately demonstrated that the capacity added to the in-house agency in the subsequent cost years would have been required in 1986 if the Medicare accounts had been sent to the agency.

1987. Hence, despite any allowances for prior years, the Provider's practice of only referring non-Medicare accounts to the in-house collection agency does not conform with the "rules in effect as of August 1, 1987.[16] Thus, the moratorium is not applicable to the facts of this case.

DECISION

The decision of the Provider Reimbursement Review is reversed. The Intermediary properly disallowed the costs of the Provider's claimed Medicare bad debts.

THIS CONSTITUTES THE FINAL ADMINISTRATIVE DECISION OF THE SECRETARY OF HEALTH AND HUMAN SERVICES

Date: 9/8/93

s/ illegible
Bruce C. Vladeck
Administrator
Health Care Financing
Administration

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16. Section 6023 of the OBRA of 1989. The Administrator notes that section 310.2 of the Manual, at issue in this case, was in effect prior to August 1, 1987. *See also, supra,* agency memorandum of June 11, 1990 regarding the effect of the moratorium on HCFA's bad debt policy.

APPENDIX D — PROVIDER REIMBURSEMENT REVIEW BOARD HEARING DECISION — *UNIVERSITY HOSPITAL v. BLUE CROSS AND BLUE SHIELD ASSOCIATION*

PROVIDER REIMBURSEMENT REVIEW BOARD HEARING DECISION

93-D55

DATE OF HEARING—
December 2, 1992

Cost Reporting Period Ended —
December 28, 1986

CASE NO. 89-1638

PROVIDER- University Hospital
Augusta, GA

Provider No. 11-0028

VS

INTERMEDIARY- Blue Cross and Blue Shield Association/
Blue Cross and Blue Shield of Georgia

* * *

ISSUE:

Whether the Intermediary's adjustment disallowing Medicare bad debts claimed by the Provider was proper.

Appendix D

SUMMARY OF FACTS:

The Provider is a general, short-term, non-profit teaching hospital located in Augusta, Georgia. On its an filed Medicare cost report for the fiscal year ending (FYE) December 28, 1986, the Provider included a claim for Medicare bad debts. The Intermediary's adjustment disallowed the Provider's Medicare bad debts claim because the Provider had not used similar efforts to collect its Medicare and non-Medicare bad debts as required by the Provider Reimbursement Manual (HCFA Pub. 15-1) § 310. The Provider appealed the Intermediary's adjustment to the Provider Reimbursement Review Board (Board) pursuant to 42 C.F.R. §§ 1835-.1841 and has met the jurisdictional requirements of these regulations. The amount of Medicare reimbursement in controversy is approximately $524,800.

PROVIDER'S CONTENTIONS:

The Provider contends that its collection practices constitute a reasonable effort to collect the Provider's Medicare accounts pursuant to 42 C.F.R. § 413.80(e)(2). The Provider indicates that it treated both Medicare and non-Medicare accounts in precisely the same manner during the first 120 days. The Provider indicates that its collection procedures included billing, subsequent billing, follow-up letters, telephone and personal contacts and each account was evaluated for collection potential. The Provider states that at the end of the 120 day period, both Medicare and non-Medicare uncollected accounts were written off as bad debts. The Provider asserts that its collection procedures in the first 120 days constituted a genuine, rather than token, effort to collect all accounts. The Provider asserts that the Intermediary has admitted that the Provider's 120 day collection process was a reasonable collection effort that fulfilled

the regulations governing Medicare bad debt reimbursement (Tr. at pp. 71 and 89).

The Provider presents data showing that using its present collection methods for Medicare accounts it collected an average of 85 percent of the amount due over the last ten years. The Provider states that for the same ten year period it was more successful in collecting Medicare accounts than non-Medicare accounts. The Provider indicates that during the four years preceding the FYE 1986 it was 1 to 5 percent more successful; that in FYE 1986 it was 6 percent more successful; and, in subsequent years, as high as 9 percent more successful.

The Provider indicates that its decision not to take further collection action on Medicare accounts after 120 days is justified by the following factors. First, it has very experienced management staff who are intimately familiar with the demographic population served by the Provider and with the psychology and needs of the older segment of the population it serves. Second, it has empirical evidence that it is more successful in collecting Medicare accounts than non-Medicare accounts during the 120 day collection period. And third, it has the assessment of representatives who are in direct contact with Medicare accounts about available assets that may be used to satisfy the obligation should further action be taken.

The Provider indicates that its knowledge of its community and its older population as well as empirical evidence led it to conclude that the Medicare eligible population would pay an account rather than risk a poor credit rating. The Provider asserts that the older community is very concerned with their credit rating and generally will do anything to avoid having it affected (Tr. at 24). Based upon this knowledge of and contact with the

Medicare patient population, the Provider has concluded that "if these folks could pay, they would during the 120 day collection process" (Tr. at 24). The Provider states that its analysis of non-Medicare accounts using the same types of information sources does not yield a similar universal principal for deciding all non-Medicare accounts as it does for the Medicare population and therefore it is appropriate for non-Medicare claims to be referred for further collection.

The Provider argues that it was also a sound business judgement not to take further action to collect Medicare accounts and presents evidence that further collection effort on Medicare accounts is not cost-effective. The Provider notes that in 1989 it began to refer Medicare accounts to its in-house collection agency. The Provider indicates that the increased costs incurred to collect Medicare accounts was not offset by the amount of additional Medicare funds collected. The Provider indicates the following losses in each of the three years since 1989.

1989 — The Provider lost $34,820.
1990 — The Provider lost $884.
1991 — The Provider lost $62,552.

Provider Exhibits 12, 13 and 14.

The Provider notes that its losses were computed in accordance with Medicare accounting regulations found at 42 C.F.R. §§ 413.5 and 413.9 and HCFA Pub. 15-1 § 2102.1. The Provider asserts that the Intermediary's analysis of the cost of collection effort using incremental costs without taking into account indirect costs is not consistent with generally accepted accounting principals (GAAP). The Provider notes that the Intermediary admits that the Medicare program requires full cost accounting (Tr. at 75).

Appendix D

According to the Provider the following facts are undisputed and are the only facts relevant to this case.

1. The Provider engaged in a reasonable collection effort in collecting its Medicare accounts that is in full compliance with 42 C.F.R. § 413.80(e)(2);

2. The Provider exercised reasonable judgement in the development and implementation of its collections practices, including the decision not to send Medicare accounts to its in-house collection agency; and,

3. Empirical evidence that is available on the face of the Provider's cost reports, and calculated in accordance with both Medicare and GAAP, objectively supports the Provider's initial decision regarding referral of Medicare accounts to its in-house collection agency.

The Provider indicates that having complied with all regulatory requirements for a reasonable collection effort, its compliance is being reversed by provisions in HCFA Pub. 15-1 that do not have the force and effect of law. The Provider notes that the Medicare regulations set out the following four part test to determine whether Medicare bad debts should be allowed.

1. The debt must be related to covered services and derived from deductible and coinsurance amounts;

2. The provider must be able to establish that reasonable collection efforts were made;

3. The debt was actually uncollectible when claimed as worthless; and,

4. Sound business judgement established that there was no likelihood of recovery at any time in the future.

42 C.F.R. §§ 413.80(e)(1),(2),(3), and (4).

The Provider states that the only issue in controversy is whether the Provider engaged in reasonable collection effort as required by 42 C.F.R. § 413.80(e)(2). The Provider asserts that the Intermediary did not challenge and admits that (1) the debts were actually uncollectible when they were written or charged off by the Provider and (2) sound business judgement established that there was no likelihood of recovery at any time in the future. The Provider indicates that the Intermediary's position is based on only one fact: that after the Provider engaged in a reasonable collection effort for a period of at least 120 days, the Provider did not turn over Medicare accounts to the in-house collection agency which the Intermediary admits were worthless and uncollectible at any time in the future. The Provider asserts that based upon the evidence in the record and the admissions of the Intermediary, the Intermediary's adjustment is arbitrary, capricious and unsupported by evidence in the record.

The Provider also argues that the Board should decide for the Provider because the Intermediary has admitted that the Provider has engaged in a reasonable collection effort in accordance with 42 C.F.R. § 413.80(e)(2). The Provider asserts that the Intermediary admitted that if the Provider had ceased all its collection efforts after 120 days all of the Provider's costs associated with Medicare bad debt would have been allowed (Tr. at 71). The Provider argues that this is an admission that the Provider's process of collecting Medicare accounts was in full compliance with the applicable regulations.

The Provider further argues that it is permitted to refer only non-Medicare accounts to its in-house collection service after a reasonable collection effort if the Provider can provide evidence of the initial reason for this policy. The Provider states that the Intermediary relies solely on the HCFA Pub. 15-1 § 310 which says that efforts to collect Medicare accounts must be "similar" to efforts to collect non-Medicare accounts to be a reasonable collection process. The Provider asserts that the Intermediary has incorrectly interpreted this provision. The Provider indicates that it may send only non-Medicare accounts to a collection agency if it undertakes a reasonable collection effort and has a justifiable reason for treating Medicare accounts differently. The Provider cites a Board decision in which a reasonable collection effort was found even though the provider treated Medicare and non-Medicare claims differently with regard to referral to a collect agency, *Humana Hospital - Sunrise (Humana) vs. Aetna Life Insurance Company*, PRRB Decision No. 92-D41, July 17, 1992. The Provider acknowledges the Board decision was reversed by the Administrator, *Humana*, HCFA Administrator Decision, September 11, 1992, but indicates that *Humana* has been appealed. The Provider also acknowledges the Board subsequently rendered a decision consistent with the *Humana* decision in *Bradford County Hospital (Bradford) vs. Blue Cross and Blue Shield Association/Blue Cross Florida*, PRRB Decision No. 92-D72, September 30, 1992, which was affirmed by the Administrator in *Bradford*, HCFA Administrator Decision, November 24, 1992.

The Provider argues that the instant case is distinguishable from both *Humana* and *Bradford*, because it has submitted empirical evidence of its lack of success in collecting Medicare accounts and presented a rational basis for not turning Medicare accounts over to the in-house collection agency. The Provider notes that

the facts in this case are similar to those in two earlier Board decisions in which the provider's practice of referring only non-Medicare accounts to collection agencies was found reasonable, *Reed City Hospital (Reed) vs. Blue Cross Blue Shield Association/Blue Cross and Blue Shield of Michigan*, PRRB Decision No. 86-D67, February 20, 1986, and *St. Francis Hospital and Medical Center (St. Francis) vs. Blue Cross and Blue Shield Association/Kansas Hospital Service Association Inc.*, PRRB Decision No. 86-D21, November 12, 1985. In *Reed*, reasonable collection effort was found because the provider's experience collecting bad debts revealed that the results of submitting Medicare accounts to a collection agency would have been negligible due to the highly indigent population in its service area and the provider's subsequent attempt to collect Medicare accounts with a collection agency produced insignificant results. In *St. Francis*, reasonable collection effort was found because the provider had referred its Medicare accounts to the collection agency and these efforts were shown to be too costly.

The Provider argues that *Reed* and *St. Francis* establish the following "test" for a provider to establish a reasonable collection effort.

> A provider complies with the reasonable collections effort required by 42 C.F.R. § 413.80(e) when the provider only refers non-Medicare accounts to an outside collection agency after a genuine in-house collection effort of at least 120 days *if* the provider can provide evidence of the initial reason for this policy.

Provider Posthearing Brief, page 20.

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The Provider indicates that it meets the test because it submitted evidence that the reason for its policy is its historically high collection of Medicare accounts in the first 120 days, its intimate knowledge of the elderly in its community, and its individual contact with Medicare beneficiaries and/or their representatives. The Provider indicates that its business judgement not to refer Medicare accounts had been validated by the losses it has suffered referring Medicare accounts to the in-house collection agency since 1989.

The Provider notes that the Intermediary is arguing that the Provider's economic losses from referring Medicare accounts for further collection are not relevant because this consideration is not explicit in the regulation or manual provisions. The Provider argues that this interpretation is not correct because all Medicare providers are to be guided by the "Prudent Buyer Principal" as delineated in HCFA Pub 15-1 § 2103. The Provider also indicates that requiring it to suffer a loss in pursuing collection of Medicare accounts in contrary to regulations requiring costs of Medicare patients not be borne by other patients since these costs must come from other patient revenue, 42 C.F.R. § 413.5(a).

The Provider also indicates that the Intermediary is not correct in its claim that Medicare has contributed to the support of its in-house collection agency and therefore entitled to have it used to collect Medicare accounts. The Provider indicates that with the advent of the prospective payment system such cost based reimbursement was eliminated.

The Provider notes that the Intermediary disagrees with the Provider's claim that it has suffered losses in referring its Medicare accounts to its in-house collection agency. The

Provider states that the Intermediary's analysis is based upon an incremental cost analysis, a cost accounting method not recognized by Medicare regulations at 42 C.F.R. § 413.5 and HCFA Pub. 15-1 § 2021.1 or by GAAP. The Provider indicates that the Intermediary cannot just count direct additional costs incurred in referring Medicare claims. The Provider indicates that the data it presented, which show three years of losses on Medicare accounts, was prepared in accordance with GAAP.

The Provider states that there are no objective standards for determining whether a provider has met its obligation to reasonably collect Medicare bad debts. The Provider suggests that the Board adopt the following presumptive standard.

> If the Provider collects at least 85 percent of its Medicare accounts, and the percentage of Medicare accounts is greater than the collection of non-Medicare accounts, then the Provider has engaged in a reasonable collection effort.

Provider Post Hearing Brief, page 28.

The Provider indicates that its collection efforts have met the proposed presumptive standard,

The Provider further argues that the Intermediary's interpretation of HCFA Pub. 15-1 § 310(A) is not correct. The Provider presents a different interpretation and indicates why the requirement is not applicable to the Provider. First, the Provider notes that HCFA Pub. 15-1 § 310(A) stated that, "A provider's collection effort *may* include the use of a collection agency in addition to, or in lieu of subsequent billing, follow-up letters, or telephone and personal contacts (emphasis added)." The

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Provider indicates it did not use a collection agency in lieu of subsequent billing, follow-up letters, or telephone contacts. The Provider notes that its in-house collection process had all these features and that they constituted a genuine effort to collect. Second, it notes that HCFA Pub. 15-1 § 310(A) states, "Where a collection agency is used, Medicare 'expects' the provider to refer all uncollected patient charges of like amount to the agency without regard to class of patient." (Emphasis added.) The Provider indicates that word "expects" denotes a guideline rather than a requirement and more importantly, the sentence only refers to a situation where the provider makes a judgement solely upon the value of the account. The Provider asserts that it has presented undisputed testimony that it did not make its determination based upon the value of the accounts but instead on an analysis of the assets and collectibility of accounts. Third, it notes that HCFA Pub. 15-1 § 310(A) states that, "The 'like amount' requirement *may* include uncollected charges above a specified amount." (Emphasis added.) The Provider notes again that this guideline is referring to a value-of-account-based process which it did not use. And finally, the Provider notes that § 310(A) states that:

> Therefore, if a provider refers to a collection agency uncollected non-Medicare patient charges which in amount are comparable to the individual Medical deductible and co-insurance amount due the provider from its Medicare patients, Medicare *requires* the provider to also refer its uncollected Medicare deductible and co-insurance amounts to the collection agency.

HCFA Pub. 15-1 § 310(A) (emphasis added).

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The Provider indicates that even though the word "requires" is used it is modified by the word "therefore" meaning it is to be read in the light of the previous sentence which states that a provider "may" include like amounts. Again, the Provider indicates that it did not use an amount of accounts method to determine which cases to forward to the collection agency and therefore the last sentence is not applicable to the Provider.

Finally, the Provider argues that, if it does not prevail on the merits of its other arguments, the Intermediary's disallowance of the Medicare bad debts violated the statutory mandate promulgated by Congress which required intermediaries to adhere to the same bad debt reimbursement practices that were in effect on August 1, 1987. The Provider refers to § 4008(c) of the Omnibus Budget Reconciliation Act (OBRA) of 1987, as amended by § 8402 of the Technical and Miscellaneous Revenue Act of 1988, which states:

> In making payments to hospitals under title XVIII of the Social Security Act, the Secretary of Health and Human Services shall not make any change in the policy in effect on August 1, 1987, with respect to payment under title XVIII of the Social Security Act to providers for reasonable costs related to unrecovered costs associated with unpaid deductible and coinsurance amounts incurred under such title (including criteria for what constitutes a reasonable collection effort), including criteria for indigence determination procedures, for record keeping, and for determining whether to refer a claim to an external collection agency.

OBRA 1987, § 4008(c).

The Provider notes that Congress clarified this provision in § 6023 of OBRA 1989 to make clear that intermediary reimbursement practices in effect in 1987 were to remain in place.

> The Secretary may not require a hospital to change its bad debt collection policy if a fiscal intermediary, in accordance with the rules in effect as of August 1, 1987, with respect to criteria for indigency determination procedures, record keeping, and determining whether to refer a claim to an external collection agency, has accepted such policy before that date. . . .

OBRA 1989, § 6023.

The Provider asserts that it made a reasonable collection effort from 1982 to 1987 and that the Intermediary approved the Provider's collection process. The Provider asserts that its case is distinguishable from *Bradford*, supra, because in *Bradford*, the Provider only relied on the advice of the Intermediary as justification for its collection process and did not provide proof of the basis for its collection policy. The Provider asserts it has provided the necessary proof that it complied with 42 C.F.R. § 413.80(e) and associated HCFA Pub. 15-1 provisions.

INTERMEDIARY'S CONTENTIONS:

The Intermediary contends that the Provider applied an equal collection effort to all accounts during the first part of the collection process but that after a certain point non-Medicare accounts were sent to an in-house collection agency for additional collection effort and no further collection effort was made for Medicare accounts.

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The Intermediary notes that 42 C.F.R. § 413.80(e) specifies four requirements for bad debts to be reimbursable, supra. The Intermediary contends that the adjustment was in accordance with 42 C.F.R. § 413.80(e)(2) because the Provider did not make a reasonable collection effort. The Intermediary notes that HCFA Pub. 15-1, § 310 further expands on the meaning of the term "reasonable collection effort."

> To be considered a reasonable collection effort, a provider's effort to collect Medicare deductible and coinsurance amounts must be similar to the effort the provider puts forth to collect comparable amounts from non-Medicare patients. It must involve the issuance of a bill on or shortly after discharge or death of the beneficiary to the party responsible for the patient's personal financial obligations. It also includes other actions such as subsequent billings, collection letters and telephone calls or personal contacts with this party which constitute a genuine, rather than a token, collection effort. The provider's collection effort may include using or threatening to use court action to obtain payment.
>
> A. Collection Agencies. — A provider's collection effort may include the use of a collection agency in addition to or in lieu of subsequent billing, follow-up letters, telephone and personal contacts. *Where a collection agency is used, Medicare expects the provider to refer all uncollected patient charges of like amount to the agency without regard to class of patient.* The "like amount" requirement may include uncollected charges above a

> specific minimum amount. Therefore, if the provider refers to a collection agency its uncollected non-Medicare patient charges which in amount are comparable to the individual Medicare deductible and coinsurance amounts due the provider from its Medicare patients, Medicare requires the provider also refer its uncollected Medicare deductible and coinsurance amounts to the collection agency. Where a collection agency is used, the agency's practices may include using or threatening to use court action to obtain payment.

HCFA Pub. 15-1 § 310 (emphasis added).

The Intermediary notes that the Provider used a collection agency but did not "refer all uncollected patient charges of like amount to the agency without regard to class of patient" as required by HCFA Pub. 15-1 § 310(A).

The Intermediary disagrees with the Provider's argument that its effort to collect both Medicare and non-Medicare accounts up until referral to the collection agency was a reasonable collection effort as required by the regulation and that the decision to take further action on non-Medicare accounts does not affect its having complied with the reasonable effort requirement of the regulation. The Intermediary states that this would disregard the requirements of HCFA Pub. 15-1 § 310(A). The Intermediary also cite the Administrator's decision in *Humana*, supra, in support of its position. In this case, the Provider was required to follow the equal collection effort rule

in HCFA Pub. 15-1 § 310(A) even though the accounts could have been deemed uncollectible under HCFA Pub. 15-1 § 310.2 due to the passage of a specified time. The decision notes that HCFA Pub. 15-1 § 310(A) is consistent with the objectives and purpose of the regulation and that § 310(A) reasonably requires, in cases where a collection agency is used, that the provider refer all uncollected patient charges of a like amount to the agency without regard to class of patient. In addition, the decision notes that under § 310(A), Medicare accounts of comparable amounts cannot properly be claimed as worthless, if the provider failed to use similar collection efforts for Medicare and non-Medicare accounts. The Intermediary notes similar findings in the Board and the Administrator's decision in *Bradford*, supra.

The Intermediary disagrees with the Provider's contention that further collection action on Medicare claims is not required, because it would not be cost-effective, for several reasons. First, the Intermediary indicates that there to no cost-effectiveness exception to the equal effort rule. Second, the Intermediary notes that the collection agency utilized was in-house. The Intermediary asserts that Medicare has reimbursed the Provider for its collection efforts and it is unfair to limit use of the in-house collection agency to non-Medicare accounts. And finally, the Intermediary indicates that the Provider's statement that it would not have been cost effective is not supported by the record. The Intermediary asserts that the Provider did not provide specific enough information to determine what additional costs were incurred, the sources of those costs or whether they were attributable to the collection of Medicare accounts. The Intermediary also indicates that the information provided did not pertain to FYE 1986. The Intermediary further notes that even using the Provider's methodology it appears that the

Provider has expended $13,247 in costs and has collected $50,172 in Medicare accounts (Provider Exhibit 11).

The Intermediary asserts that the Provider did not provide any evidence to support its assertion that the "older community" is concerned about their credit rating and therefore they would have paid their bills had they been able to do so. The Intermediary notes testimony confirming that there was no cost analysis for FYE 1986 (Tr. at 36 and 37) and indicates that cost analyses for 1989 and later years are not relevant to 1986. The Intermediary further contends that the Provider's methodology of full cost accounting using the claim to allocate overhead costs is inappropriate because the procedures used and costs incurred to collect small Medicare accounts are unlikely to be the some as those used to collect larger non-Medicare claims.

CITATION OF LAW, REGULATIONS, AND PROGRAM INSTRUCTIONS:

1. *Law — Title XVIII of the Social Security Act*:

   § 1861(v)(1)(A) — Reasonable Cost

2. *Regulations - 42 C.F.R.*:

§ 413.5	—	Cost Reimbursement - General
§ 413.9	—	Costs Related to Patient Care
§ 413.80	—	Bad Debts, Charity and Courtesy Allowances
§ 413.24	—	Adequate Cost Data and Cost Finding

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3. *Program Instructions - HCFA Pub. 15-1, Part I:*

§ 310	—	Reasonable Collection Effort
§ 312	—	Indigent and Medically Indigent Patients
§ 2102.1	—	Reasonable Costs
§ 2103	—	Prudent Buyer

FINDINGS AND CONCLUSIONS:

The Board, after consideration of the facts, parties' contentions, evidence presented, testimony elicited at the hearing, and posthearing briefs, finds and concludes as follows:

The Board finds that the Intermediary was not correct in disallowing the Medicare bad debts claimed by the Provider for FYE 1986. The issue in this case is whether the Provider made a reasonable effort to collect its Medicare bad debts where the Provider used the same genuine effort to collect all its accounts for 120 days, has written off as bad debts all its accounts uncollected after 120 days, and has subsequently sent its non-Medicare accounts *but not its Medicare accounts* to its in-house collection agency.

The Board notes that the Provider claimed Medicare bad debts in the same manner as had been its custom for prior years. The principal facts in this case are not in dispute. The record indicates that the Provider had the same collection procedure for both its Medicare and non-Medicare accounts during the first 120 day period. The collection effort involved billing, follow-up billing, letters, and telephone or personal contacts. The record indicates that the Provider and Intermediary testified that the Provider's

collection efforts in the first 120 day period constituted a genuine, not a token, effort to collect Medicare bad debts. The record contains data on the percentage of Medicare bad debts collected both prior to and subsequent to the year under appeal to substantiate the effectiveness of the Provider's collection efforts. The Provider and Intermediary have even stipulated that the Provider's efforts in the first 120 days were genuine and not a token collection effort.

After the 120 day period, the Provider's practice was to write off all accounts, both Medicare and non-Medicare. The Provider notes that for Medicare accounts this practice was in compliance with the provision of HCFA Pub. 15-1 § 312. The Board further notes that the Intermediary's witness indicated that the Provider's collection effort up to 120 days was reasonable and genuine and had the Provider's collection practice ended after 120 days, the case would never have arisen (Tr. at 71).

The Board notes that in *Bradford*, supra, the Provider failed to indicate any reason for not forwarding Medicare accounts to the collection agency and therefore could not establish a reasonable collection effort. In the instant case, the Board finds that the Provider is required to and has provided a valid reason for not sending its unpaid Medicare accounts to the collection agency. The Board finds that the valid reason was based upon sound business judgement and that the Provider presented credible evidence to support this decision. The Board finds that the Provider has made a reasonable effort to collect these accounts. The Board notes two previous decisions, *Reed*, and *St. Francis*, supra, in which a reasonable collection effort was found in situations where Medicare accounts were not forwarded to collection agency for further collection. In *Reed*, the Board found the provider's collection efforts reasonable where it

showed that it did not submit Medicare accounts to a collection agency because the recovery rate would have been negligible due to the highly indigent population in its service area and subsequent collection efforts produced insignificant results. Likewise, in *St. Francis*, the Board found that the provider's referral of Medicare accounts to a collection agency in subsequent years, which resulted in no recoveries from Medicare beneficiaries, justified the provider's actions in not referring Medicare accounts to a collection agency in the earlier years at issue.

In the instant case, the Provider indicates that a number of factors contributed to its decision not to refer Medicare accounts to its in-house collection agency and that its decision was validated by poor recoveries in subsequent years. The Provider's factors include the following:

- very high percentage of its Medicare deductibles and co-insurance accounts were collected in the first 120 days;

- An extremely experienced staff with knowledge of the elderly community which it serves and their extreme concern with their credit rating; and,

- The assessment of their collection personnel who had analyzed Medicare accounts for assets and collectibility.

The Board finds the record supports the reasonableness of the Provider's rationale for not referring Medicare claims for further collection. The Board also found evidence in the record that the Provider had knowledge of the Medicare population in its community and did assess Medicare accounts for assets and

collectibilty. In addition, and more importantly, the Board finds the evidence presented by the Provider of three years of losses from its subsequent efforts to collect Medicare accounts to be proper validation of its initial decision not to further pursue Medicare accounts.

The Board finds that the accounting methods used by the Provider to allocate its collection costs were proper and in accordance with Medicare principles. The Board finds that Provider has properly demonstrated that it had suffered losses in collecting Medicare accounts from 1989 to 1991.

The Board also rejects the Intermediary's argument that HCFA Pub. 15-1 § 310 does not contain an exception for cost-effectiveness. The Board finds that it would not be logical to insist that a provider, in order to demonstrate reasonable collection effort, adopt collection practices prescribed in HCFA Pub, 15-1 § 310, when it can demonstrate it costs more to collect a patient's bill than the amounts they expect to collect. The Board notes that one of the regulatory criteria for a provider to meet before bad debts may be claimed permits a provider to use "sound business judgement" regarding the likelihood of recovery, as found in 42 C.F.R. § 413.80(e)(4).

The Board finds that the Provider has presented a reasonable rationale for its different collection practice for Medicare accounts as well as evidence to support its position. Therefore, the Board finds that the Provider has engaged in a reasonable collection effort as required by 42 C.F.R. § 413.80(e)(2).

The Board having found for the Provider on other grounds has not addressed the issue raised concerning OBRA.

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DECISION:

The Intermediary's adjustment disallowing Medicare bad debts was not proper. The Intermediary's adjustment is reversed.

Board Members Participating:

Jack Martin
Joseph F. Sloan
J. A. Roark, Sr.

FOR THE BOARD:

stamp [illegible]

s/ Jack Martin
Jack Martin
Chairman

APPENDIX E — DECISION OF THE UNITED STATES COURT OF APPEALS FOR THE ELEVENTH CIRCUIT DATED NOVEMBER 26, 1997

UNITED STATES COURT OF APPEALS
ELEVENTH CIRCUIT

No. 95-9493

UNIVERSITY HEALTH SERVICES, INC.,

Plaintiff-Appellee,

versus

HEALTH & HUMAN SERVICES, Donna Shalala, in her official capacity as Secretary,

Defendant-Appellant.

On Appeal from the United States District Court for the Southern District of Georgia.

BEFORE: BIRCH, BLACK and CARNES, Circuit Judges.

PER CURIAM:

The petition(s) for rehearing filed by Appellee UNIVERSITY HEALTH SERVICES, INC. is DENIED.

ENTERED FOR THE COURT:

s/ illegible
UNITED STATES CIRCUIT JUDGE

APPENDIX F — JUDGMENT OF THE UNITED STATES COURT OF APPEALS FOR THE ELEVENTH CIRCUIT DATED AUGUST 28, 1997

UNITED STATES COURT OF APPEALS
FOR THE ELEVENTH CIRCUIT

No. 95-9493

D.C. Docket No. CV193-180

UNIVERSITY HEALTH SERVICES, INC.,

Plaintiff-Appellee,

versus

HEALTH & HUMAN SERVICES, Donna Shalala, in her official capacity as Secretary,

Defendant-Appellant.

Appeal from the United States District Court for the Southern District of Georgia.

Before BIRCH, BLACK and CARNES, Circuit Judges.

JUDGMENT

This cause came to be heard on the transcript of the record from the United States District Court for the Southern District of Georgia, and was argued by counsel;

UPON CONSIDERATION WHEREOF, it is now hereby ordered and adjudged by this Court that the judgment of the

said District Court in this cause be and the same is hereby REVERSED; and that this cause be and the same is hereby REMANDED to said District Court with instructions for further proceedings in accordance with the opinion of this Court;

It is further ordered that plaintiff-appellee pay defendant-appellant the costs on appeal to be taxed by the Clerk of this Court.

Entered: August 28, 1997
For the Court: Miguel J. Cortez, Clerk

By: s/ Matt Davidson
Deputy Clerk

ISSUED AS MANDATE: 12/5/97

APPENDIX G — OMNIBUS BUDGET RECONCILIATION ACT OF 1987, AS AMENDED

Continuation of Bad Debt Recognition for Hospital Services

In making payments to hospitals under title XVIII of the Social Security Act [this subchapter], the Secretary of Health and Human Services shall not make any change in the policy in effect on August 1, 1987, with respect to payment under title XVIII of the Social Security Act [this subchapter] to providers of service for reasonable costs relating to unrecovered costs associated with unpaid deductible and coinsurance amounts incurred under such title (including criteria for what constitutes a reasonable collection effort, including criteria for indigency determination procedures, for record keeping, and for determining whether to refer a claim to an external collection agency).

The Secretary may not require a hospital to change its bad debt collection policy if a fiscal intermediary, in accordance with the rules in effect as of August 1, 1987, with respect to criteria for indigency determination procedures, record keeping, and determining whether to refer a claim to an external collection agency, has accepted such policy before that date, and the Secretary may not collect from the hospital on the basis of an expectation of a change in the hospital's collection policy.

Appendix G

Omnibus Budget Reconciliation Act of 1987, Pub. L. No. 100-203, § 4008(c), as amended by Technical and Miscellaneous Revenue Act of 1988, § 8402 and OBRA of 1989, § 6023.

APPENDIX H — PROVIDER REIMBURSEMENT REVIEW BOARD HEARING DECISION DATED FEBRUARY 20, 1986 — *REED CITY HOSPITAL v. BLUE CROSS AND BLUE SHIELD ASSOCIATION*

Reed City Hospital (Reed City, Michigan) v. Blue Cross And Blue Shield Association/Blue Cross And Blue Shield Of Michigan

PRRB *Hearing Dec.* No. 86-D67, Feb. 20, 1986 (cost reporting period ending June 30, 1982).

Medicare: Bad Debts and Collection Fees

Provider reimbursement — Bad debts — Reasonable collection effort. — A provider's experience with collecting bad debts revealed that the results of submitting Medicare accounts to a collection agency would have been negligible due to highly indigent population in its service area. After an Intermediary audit, the provider began forwarding its delinquent, Medicare patient accounts to a collection agency with insignificant results. Since the Intermediary had agreed that the provider's in-house collection efforts were genuine and that a reasonable collection effort had been made, as defined in *Manual*/Sec. 310, the provider was held to have met the Medicare bad debt collection standards as required by the regulations.

* * *

Provider reimbursement — Bad debts — Collection fees — Reasonable collection efforts. — Since the provider's in-house collection procedures for overdue Medicare accounts were found to be adequate, the provider's decision to send only non-Medicare delinquent accounts to a collection agency was a sound

one. Accordingly, the collection agency fees incurred by the provider for non-Medicare bills were found to be necessary and proper administrative expense.

* * *

ISSUES

1. Whether the Intermediary's adjustment of denying reimbursement of Medicare bad debts is correct?

2. Whether the Intermediary's adjustment of disallowing collection agency fees incurred by the provider is correct?

SUMMARY OF FACTS

The provider, a general, short-term hospital, timely filed its appeal and has met all of the requirements of 42 C.F.R. 405.1835ff of the Health Care Regulations.

Issue 1 — Medicare Bad Debts:

The provider's accounts receivable collection policy included: (1) obtaining deposits from patients; (2) attempting to collect all deductibles at the time of admission; (3) evaluating patients' capability to pay; (4) determining Hill-Burton Eligibility; (5) establishing procedures to collect billings within 90 days; and (6) sending unpaid accounts to a small claims court or a collection agency if not paid within 90 days. Only non-Medicare bad debts were sent to the collection agency. As a result of this practice, the Intermediary denied $16,626 of Medicare bad debts based on the requirement of Provider Reinbursement Manual (PRM) Sec. 310 [¶ 5233] — Reasonable

Collection Effort. This resulted in a reduction in Medicare reimbursement of approximately $17,000.

Issue 2 — Collection Agency Fees:

As a result of sending non-Medicare bills to the collection agency, the provider incurred $8,263 in collection agency fees. The Intermediary denied these costs because it did not meet the reasonable collection effort requirements of P.R.M., Sec. 310. This resulted in a reduction in Medicare reimbursement of approximately $3,000.

PROVIDER'S CONTENTIONS

Issue 1 — Medicare Bad Debts:

The provider contends that it has met the reasonable collection effort requirements of 42 CFR 405.420 — Bad Debts, Charity and Courtesy Allowances, and P.R.M., Sec. 310. Therefore, its Medicare bad debts are reimbursable. It contends that it adhered to its accounts receivable policy and applied it equally to all patients. It did not submit the Medicare uncollectibles to the collection agency because its recovery rate would have been negligible due to the highly indigent population of its service area. Further, since the Intermediary audit, the provider is now forwarding its delinquent Medicare patient accounts to the collection agency with virtually insignificant results. Finally, Board decisions 84-D109 (*St. Joseph's Hospital*), and 84-D-174 (*Scotland Memorial Hospital*), support the provider's position that Medicare bad debts and collection agency fees are allowable when reasonable in-house collection efforts are made.

Appendix H

Issue 2 — Collection Agency Fees:

In addition, to its contentions set forth with regards to Issue 1 above, the provider believes its collection agency fees are allowable pursuant to 42 C.F.R. 405.451

INTERMEDIARY'S CONTENTIONS

Issue 1 — Medicare Bad Debts:

The Intermediary contends that the provider has not met the reasonable collection effort requirements of either 42 C.F.R. 405.420 or P.R.M., Sec. 10, because similar collection efforts were not made for all patients. The provider did not submit Medicare accounts deemed uncollectible to the collection agency while it did submit similar non-Medicare accounts. Further, there is no evidence to show that the collection agency refused to accept Medicare. P.R.M., Sec. 310, requires a provider to notify the collection agency not to threaten to sue a medicare beneficiary. No evidence exists that a provider rendered such notice.

Issue 2 — Collection Agency Fees:

The provider has expended $8,263 for the use of a collection agency to recover uncollectible *non*-Medicare receivables. For collection agency fees to be considered an allowable cost, HCFA Pub. 15-1, Sec. 310.1, states that:

> Where a provider utilizes the services of a collection agency and the reasonable collection effort criteria described in Sec. 310 is applied, the fees the collection agency charges the provider are

recognized as an allowable administrative cost of the provider.

Sec. 310.1 establishes a condition precedent for collection fees to be deemed allowable costs. The condition precedent is that the criteria described in PRM, Sec. 10, and 42 C.F.R. 405.420 must be fulfilled. As previously discussed, the provider did not meet the reasonable collection effort criteria required in 42 C.F.R. 405.420 and Sec. 310 because it did not use the same or identical procedures for its Medicare accounts as it did for its non-Medicare accounts. The Intermediary asserts that the conditions required in Sec. 310.1 have not been fulfilled by the provider and, therefore, the collection fees are not allowable costs.

* * *

Conclusions and Findings:

The Provider Reimbursement Review Board (Board), after considering the facts, contentions of the parties and evidence presented, concludes and finds as follows:

Issue I — Medicare Bad Debts:

The Board finds that, based on facts and uncontroverted evidence submitted, the provider's collection policies reflect that it maintained reasonable collection efforts on Medicare accounts deemed uncollectible as required in 42 CFR 405.420. The Intermediary, in fact, concurs that the in-house collection efforts were acceptable and appropriate.

Appendix H

Issue 2 — Collection Agency Fees:

The Board finds that the provider's collection agency fees are allowable under Regulations Sec. 405.451 as necessary and proper administrative and general (A&G) costs which are common and accepted occurrences in the field of the provider's activity. As A&G expenses, they should be allocated to all patients.

Decision:

Issue 1 — Medicare Bad Debts:

The Intermediary's adjustment is reversed. The provider's collection efforts are reasonable pursuant to 42 CFR 405.420 and the Medicare bad debts are allowable.

Issue 2 — Collection Agency Fees:

The Intermediary's adjustment is reversed. Collection agency fees are allowable administrative and general costs.

APPENDIX I — ADMINISTRATOR REVIEW OF AFFIRMANCE OF PROVIDER REIMBURSEMENT REVIEW BOARD'S DECISION DATED JANUARY 8, 1986

St. Francis Hospital Medical Center

v.

Blue Cross and Blue Shield Association/
Kansas Hospital Service Association, Inc.

HFCA Administrator Decision Jan. 8, 1986

Medicare: Clinic Personnel Costs

Provider reimbursement — Cost data and cost finding — General service cost centers — Clinic personnel costs. —

Although specified overhead costs for an entire facility, such as administrative and general costs, are grouped together and distributed proportionately to all of the other cost centers in the facility on the basis of relative use or benefit, in the instance of exclusive use by a specific cost center, cost may be included in that cost center only, without being part of the general distribution. A provider that reclassified the clerical costs of its clinics to the A & G cost center at the same time allocated to the clinic cost centers the costs of purchasing, receiving and stores, and other costs. However, since the clinics are nonallowable cost centers, their costs must be excluded from allowable costs in order to prevent the Medicare program from paying for services rendered to non-program patients. Since the provider's method does not yield a more accurate cost finding result, the Board correctly decided that the personnel expenses in dispute should be discretely costed to the clinics

because the employees spent all of their time working for the clinics.

* * *

[Text of Decision]

This case is before the Administrator, Health Care Financing Administration, for review of the decision of the Provider Reimbursement Review Board. The review is during the 60-day period in Section 1878(f)(1) of the Social Security Act, as amended [42 U.S.C. 1395oo]. Comments were received from the provider urging reversal of the Board's decision on Issue No. 1. The parties were notified of the Administrator's intent to review the Board's decision on issue No. 1. No comments have been received from the Intermediary and the time limit for so doing has passed. Accordingly, this case is now before the Administrator for final administrative decision.

Issue No. 1 concerns whether the Intermediary's adjustment reclassifying administrative salaries from the Administrative and General Expenses cost center (A & G) to be nonallowable outpatient clinic cost centers is correct. The Board held, after a hearing on the record without oral testimony, that the personnel expenses in dispute should be discretely costed to the clinics, because the employees spent all of their time working for the clinics. Thus, the board found that these costs did not represent general service costs under Sec. 2302.9 [¶6370] of the Provider Reimbursement Manual (HIM-15).

The provider, requesting reversal on Issue No. 1 contended that the Board's decision was inconsistent with its prior decision in the case of Katy Memorial Hospital, PRRB Dec. No. 84-

D143, which was affirmed by the Deputy Administrator. According to the provider, the material facts are similar in both cases. The provider argued that the costs in dispute were normal administrative costs, which should be included in the A & G cost center, rather than direct costs of the clinic. Discretely costing the items in dispute, the provider concluded, would cause A & G costs of the entire facility to be allocated to the clinics in addition to those costs already discretely allocated to the clinics.

The entire record that was furnished by the Provider Reimbursement Review Board has been examined, including all correspondence, position papers, and exhibits submitted by the parties. The complete statement of the facts set forth by the Board in its decision is incorporated by reference. The Board's decision has been reviewed by the Administrator. All comments received after entry of the Board's decision have been made a part of the record and considered. The issue in this case specifically concerns whether the provider is required to include in a cost center certain costs that pertain to that particular cost center. Cost finding is structured in such a way so as to distribute the provider's costs so that ultimately only the costs attributable to Medicare beneficiaries will be reimbursed by the program. This principle is enunciated in Sec. 1861(v)(1)(A) of the Social Security Act, as amended [42 U.S.C. 1395x], and 42 C.F.R. 405.402 and 405.451.

Generally, in cost finding under Medicare, specific overhead costs for the entire facility, such as administrative and general costs, are grouped together and distributed proportionately to all of the other cost centers in the facility on the basis of relative use of benefit. In the instance of exclusive use by a specific cost center, however, costs may be included in that cost center

only, without being lumped in the general distribution. This often yields a more accurate allocation of costs.

The Administrator notes that the hospital has elected to "fragment" its administrative and general costs for cost-finding purposes. This "fragmentation" allocates the costs of each of the following groups separately: telephone; data processing; purchasing; receiving and stores; admitting; cashiering accounts receivable and collections; and "other." The clinic cost centers receive only purchase, receiving and stores and "other" administrative costs through cost finding. If the provider were permitted to reclassify the clerical costs of the clinics to the A & G cost center, the statistical basis for the allocation of "other" administrative costs would have been understated. The clinics are non-allowable cost centers, the costs of which must be excluded from a hospital's allowable costs to prevent the Medicare program from paying for services rendered to non-program patients. Thus, and understatement of "other" costs to the clinics, thereby causing a greater Medicare reimbursement. The hospital has elected the alternate fragmentation method of allocating administrative and general expenses for the accuracy in cost finding the alternate provides. The provider may not in addition reclassify direct costs to further advantage its hospital reimbursement.

With respect to the case of Katy Memorial Hospital, PRRB Dec. No. 84-D148, referred to by the provider, the Administrator does not find it controlling. A review of the Board's and the Deputy Administrator's decisions in that case indicates that Katy Memorial Hospital's A & G costs were allocated as a whole, some A & G costs of the entire facility, as well as the discretely-costed clerical costs would be assigned to the non-allowable cost center. Such double allocation would clearly exclude an

excessive amount of administrative costs from Medicare reimbursement. In the present case, however, excessive allocation is prevented by allocating to the clinics only two of the six sub-groups of the provider's A & G cost centers.

It is the Administrator's opinion that based on the evidence presented in this case, it has not been shown that the provider's costs allocation method is more accurate. A review of the record in its entirety reflects that the Board's decision is supported by substantial evidence and is in keeping with the governing regulations. Accordingly, the Board's decision on Issue No. 1 that the provider's clinical personnel costs must be reclassified from the A & G cost center to the clinical cost centers is affirmed.

The Board's decision on Issue No. 2 is affirmed. The provider's Medicare bad debts, but not Medicaid and non-covered Medicare services bad debts, are allowable. Recoveries of prior year Medicare bad debts must be offset against them.

The Board's decision on Issue No. 3 is affirmed. Collection agency fees are allowable administrative costs.

This constitutes the final administrative decision of the Secretary of Health and Human Services.

APPENDIX J — PROVIDER REIMBURSEMENT REVIEW BOARD HEARING DECISION DATED NOVEMBER 12, 1985 — *ST. FRANCIS HOSPITAL AND MEDICAL CENTER v. BLUE CROSS AND BLUE SHIELD ASSOCIATION*

St. Francis Hospital and Medical Center (Topeka, Kan.) v. Blue Cross and Blue Shield Association/Kansas Hospital Service Association, Inc.

PPRB Hearing Dec. No. 86-D21, Nov. 12, 1985 (cost reporting period ending May 31, 1980, 1981, 1982, and 1983).

Medicare: Clinical Personnel Costs; Collection Agency Fees

Provider reimbursement — Cost data and cost finding — General service cost centers — Clinic personnel costs. —

Manual Sec. 2305.9 defines general service cost centers as division, departments, or subdivisions thereof that are operated for the benefit of the institution as a whole. The costs of billing and recordkeeping related to the hospital's three clinics that the provider had reclassified to the administrative and general cost center were properly reclassified by the intermediary to the clinic cost centers. The costs in dispute were direct costs of the three clinics, which are not general service cost centers, since the employees spent all of their time working in the clinics, and their services did not benefit the rest of the institution. Therefore, the salaries of the clinic employees should have been charged directly to the clinic cost centers, instead of being added to the A & G cost center, which resulted in a portion of those salaries being allocated to other hospital cost centers not served by the clinics. Rather, the clinic cost centers should have been assessed a portion of the indirect A & G costs of the provider in the normal allocation process.

Appendix J

* * *

Provider reimbursement — Bad debts — Reasonable collection efforts. —

According to Manual Sec. 310, a provider that is seeking remibursement for the cost of reasonable collection efforts, and is referring to a collection agency its uncollected non-Medicare patient charges, is required to refer its uncollected Medicared patient charges to the collection agency also. A provider claimed that it subjected all of its accounts receivable to a reasonable collection effort even though uncollected non-Medicare patient accounts were referred to a collection agency, while uncollected Medicare patient accounts were not. The provider had referred its Medicare accounts to a collection agency for the fiscal years ending 1983 and 1984; however, no amounts were recovered from the Medicare beneficiaries for the 1983 fiscal year. Since the provider had demonstrated that writing off bad debts when their pursuit would be too costly was a reasonable practice, the provider's in-house collection efforts constituted a reasonable collection effort. However, any recovery of Medicare bad debts written off in prior years must be offset against uncollected amounts.

* * *

Provider reimbursement — Bad debts — Collection agency fees. —

Manual Sec. 310 requires that, for a collection agency fee to be allowable as an administrative cost, the provider must refer all uncollected patient charges of like amount to the agency without regard to whether the patient is Medicare or non-Medicare.

However, this requirement is not in accord with Medicare regulations since the effect of Sec. 310 is to establish direct apportionment of collection agency fees, an exception to the usual allocation process requiring a regulatory exception that was never forthcoming. Accordingly, a provider that referred only non-Medicare patients' accounts to a collection agency was entitled to reimbursement for the collection agency fees.

* * *

Issues:

1. Whether the Intermediary's adjustments, which reclassified clinical personnel cost from the A & G cost center to the clinic cost center, were proper? (1981, 1982, 1983).

2. Whether the Intermediary's adjustments, which disallowed Medicare bad debts because the provider excluded all Medicare accounts from referral to an outside collection agency, were proper? (1980, 1981, 1982).

3. Whether the Intermediary's adjustments, which disallowed collection agency fees because the provider excluded all Medicare accounts from referral to an outside collection agency, were proper? (1980, 1981, 1982)

Summary of Facts:

The provider is an acute care hospital. The provider filed its cost reports for the fiscal years ending May 31, 1980, 1981, 1982, and 1983, claiming the costs in dispute as allowable. In the Notices of Program Reimbursement (NPR) issued by the Intermediary on various dates, the Intermediary reflected various

adjustments which reduced Medicare reimbursement by approximately $262,000. The provider appealed the NPR adjustments on December 28, 1984 and March 15, 1985, pursuant to 42 C.F.R. 405.1835ff and has met the jurisdictional requirements therein.

Issue 1 — Reclassification of Clinic Administrative Costs:

These Intermediary adjustments reduced Medicare reimbursement by approximately $121,000. The provider reclassified the direct costs of billing and recordkeeping for clinics operated by the hospital to the administrative and general cost center (A & G). The provider allocated its A & G expense pool on the fragmented method (HIM 15, Sec. 2313.1 [¶6475A]). The Intermediary contends that the costs of billing and recordkeeping are costs directly incurred by the clinics and may not be reclassified from those nonreimbursable costs center for cost finding purposes.

Provider's Contentions:

The provider contends that its reclassification of the billing and recordkeeping costs of the hospital's three clinics to A & G is supported by HIM 15, Part II, Sec. 306 [¶9306] and HIM 15, Part I, Sec. 2313.1(c)(2)(b)(3). The provider contends that, unless these costs are reclassified from the clinics to the A & G cost center of the hospital, the clinics will be allocated excessive A & G costs. This would occur because the statistics is used on Worksheet B-1 included gross charges of the three clinics. Personnel of the clinic perform administrative duties and are hospital employees. Also, the A & G personnel of the hospital perform administrative duties for the clinics. Certain functions performed by the administrative personnel of the clinic are also performed by the hospital.

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The following administrative duties are performed by the clinic personnel:

1. Maintain accounts receivable ledgers.

2. Collect and maintain records for cash receipts.

3. Maintain cash disbursement ledgers.

4. Make bank deposits.

5. Reconcile bank statements

6. Make direct purchases.

7. Disburse refund checks to patients.

8. Bill all patients.

9. Make collection efforts.

The provider contends that the Intermediary has forced the provider to use discrete costing, which is not compulsory under Medicare reimbursement guidelines.

Intermediary's Contentions:

The Intermediary contends that, under the provisions of Reg. Secs. 405.240, 405.451, and 405.453, the costs of billing and recordkeeping are direct costs of the provider's three clinics. As direct costs, they may not be reclassified from those cost centers. Reclassification to the administrative and general cost center "Cashier, Accounts-Receivable and Collections" results

in increasing the costs of other hospital services for services provided in those clinics.

The Intermediary contends that the provider's reclassifications were not proper for the following reasons:

> 1. The clinics are not located in the hospital building and are operated as and appear to be private physician offices;
>
> 2. The reclassified costs were distinctly identifiable with the clinics and were recorded accordingly;
>
> 3. Billings to patients are made in the name of the specified clinic;
>
> 4. Clinic billing personnel work only in the clinic and other hospital personnel do not handle clinic billings and accounts;
>
> 5. Clinic patients receive physician services and Medicare billings are coded as physician offices, not outpatient hospital services;
>
> 6. The cost center "Cashier, Accounts Receivable and Collections" is allocated on the statistical basis of charges. The charges of the clinics for physician services and diagnostic services, which are different from the hospital's usual patient charges. This resulted in a dissimilar statistical base being utilized to apportion the cost center after reclassification.

The conclusion was that the reclassification was inconsistent with Reg. Sec. 405.453, which requires providers to use

appropriate cost finding. Provider Reimbursement Manual, Sec. 2304 [¶6420], 2306 [¶6425] and 2328 [¶6670] include instructions for complying with that regulation. They specify proper cost finding methods. An adjustment was also made to revise Worksheet B-1 statistics to be consistent with the restatement of costs.

Therefore, the Intermediary concludes that Part B reimbursement would be duplicated by a reclassification of the direct costs of the clinic.

Issues 2 and 3 — Medicare Bad debts and Collection Agency Fees:

These adjustments reduced Medicare reimbursement by approximately $88,000 for the collection agency expense and $43,000 for the Medicare bad debts.

Provider's Contentions

The provider contends that it subjects all its accounts receivables accounts to a reasonable collection effort. The in-house collection effort for Medicare accounts is at least as stringent as that for all other patients accounts. The number of billings was consistent for all patients, both Medicare and non-Medicare. A bill was sent out three (3) days after a patient was discharged, and every thirty (30) days thereafter for six (6) months, at which time the Medicare accounts were written off and the non-Medicare accounts were turned over to a collection agency.

The provider referred its Medicare accounts to a collection agency for the FYE's 1983 and 1984; however, no amounts

were recovered from the Medicare beneficiaries. The Intermediary has audited the FYE 1983 cost report and verified that no amounts were recovered. The provider feels that the inability of its agency to collect in 1983 justifies its actions for FYE's 1980, 1981, and 1982 when Medicare accounts were not referred to a collection agency.

The provider also contends that the collection agency fees are allowable expenses because the A & G cost center includes expenses which relate to Medicare patients while others do not. The Medicare program shares in all of these expenses because they benefit the institution as a whole. Expenses paid to prepare a Medicare cost report relate 100% to Medicare patients, however, Medicare pays only its share. Therefore, it seems fair that Medicare pay its share of A & G expenses which do not relate to Medicare patients, such as collection agency expenses.

Intermediary's Contentions

The intermediary contends that the uncollected Medicare bad debts claimed by the provider were properly disallowed because the provider's collection efforts for non-Medicare and Medicare uncollected amounts were not consistent and, therefore, deemed not reasonable in accordance with Medicare regulations and instructions.

The Intermediary cites 42 C.F.R. 405.420(e), which sets forth the criteria for allowable bad debts. This section requires, in part, that providers must establish that reasonable collections efforts were made. In addition, Sec. 310 [¶5233] of HIM 15 defines reasonable collection efforts for Medicare purposes as being similar to the effort to collect comparable amounts from non-Medicare patients.

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The Intermediary believes that the provider's collection efforts were not reasonable because the non-Medicare uncollectable accounts were referred to an outside collection agency for further collection attempts while the Medicare uncollectable accounts were not similarly referred but were written off as bad debts.

The Intermediary also contends that the collection agency fees may not be reimbursed as they do not relate to the cost of services to beneficiaries. To include the costs with allowable costs would result in parts thereof being borne by the Medicare trust funds in violation of Reg. Sec. 405.541(c)(1).

* * *

The Provider Reimbursement Review Board, after consideration of the facts, parties' contentions, and evidence presented, concludes and finds as follows:

Issue 1 — Reclassification of Clinic Administrative Costs:

The Board finds that the evidence presented supports the Intermediary's adjustment. The Board finds that the clinic billing and recordkeeping costs are direct costs of the clinic cost centers. The record shows that the employees in question spend all their time working in and for the three clinics.

The costs in dispute, therefore, are direct costs of the three clinics, which are not general service cost centers. Conversely, the A & G cost center is a general services cost center. Sec. 2302.9 [¶6370] of HIM 15 defines general service cost centers as "those divisions, departments or subdivisions thereof, etc., which are operatd for the benefit of the institution as a whole."

Under that section, "costs incurred for these cost centers are allocated to other cost centers on the basis of services rendered." This section is relevant here for two reasons.

First, the employees of the clinic in question are of sole benefit to the three clinics. Their services do not benefit the rest of the institution. Second, the provider added the salaries of the subject clinic employes to the A & G cost center with the result that a portion of those salaries were allocated to other hospital cost centers not served by the clinic.

Issue 2 — Medicare Bad Debts:

The Intermediary's adjustments are modified. The Board finds that substantial evidence in the record demonstrates that the provider's collection efforts for Medicare uncollectable amounts meet the reasonable effort requirements of Reg. Sec. 405.420. However, the recoveries of Medicare bad debts written off in prior years must be offset against the uncollectable amounts. In addition, the bad debts for Medicaid and noncovered Medicare services are not allowable costs.

The board notes that the Intermediary's position paper (Exhibit A), indicates that the collection efforts for Medicare and non-Medicare accounts were identical up to the point when the provider turned certain delinquent accounts over to a collection agency. It is reasonable to write off bad debts when their pursuit would be too costly. While not specific to the years in question, the provider referred its Medicare accounts to a collection agency for the fiscal years ending 1983 and 1984, but did not recover amounts from them. The Board finds that the provider established that there was negligible likelihood of recovery of the Medicare bad debts.

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Issue 3 — Collection Agency Fees:

The Intermediary's adjustments are reversed. The Board finds that the providers collection agency fees are necessary and proper costs, which are common and accepted occurrences in the field of the provider's activity. They are administrative and general costs and, should be properly apportioned to all patients.

Although Sec. 310 of HIM 15-1 requires that for a collection agency fee to be allowable as an administrative cost, the provider must refer all uncollected patient charges of like amount to the agency without regard to the class of patient, i.e., whether the patient is Medicare or non-Medicare, the Board finds that such a requirement is not in accord with Medicare regulations and, therefore, the collection agency fees are allowable.

Sec. 405.451(b)(2) of the Medicare regulation states:

Necessary and proper costs are costs which are appropriate and helpful in developing and maintaining the operation of patient care facilities and activities. They are usually costs which are common and accepted occurrences in the field of the provider's activity.

Sec. 405.451(c)(3) states in part:

. . . Reasonable cost includes all necessary and proper expenses incurred in rendering services, such as administrative costs. . . .

The effect of the Sec. 310 provision is to establish direct apportionment of collection fees, an exception to the usual

allocation process. The Secretary clearly indicated that the 1979 changes permitting indirect apportionment of malpractice costs were an exception requiring a regulatory exception. No such regulatory exception has been promulgated for collection agency fees.

Finally, the board notes that the Deputy Administrator of HCFA, in upholding this conclusion in PRRB Dec. No. 83-D61, stated in part:

While Sec. 405.451 presents the regulatory analysis of "reasonable costs", Chapter 21 of the Provider Reimbursement Manual, HIM-15, presents the agency's interpretation and instructions concerning the application of this doctrine. The scope of Chapter 21 is limited where a principal subject (such as interest expense in Chapter 9) is covered in another part of the Manual. As an allowable administrative cost, any exclusion of collection agency fees would have been considered in Chapter 21. There is no such exclusionary provision in this chapter.

Sec. 310 in Chapter III does specifically address collection agencies and fees related to their services. However, the principal focus of that chapter is interpretation of 42 C.F.R. 405.420 concerning bad debts, charity and courtesy allowances. Medicare bad debts are allowable under both the regulation and the Manual; however, Section 310 of the Manual does require a sufficient effort to collect the deductible and coinsurance. Sec. 310.1 recognizes the allowance for the fees of collection agencies when collection efforts are reasonable. It does not present an exclusion of these costs under other circumstances when it is read in context of the rest of Chapter III.

The Deputy Administrator has considered the Intermediary's comments concerning the provider's failure to document the

reasonableness of its in-house collection efforts for Medicare beneficiary receivables. Under Sec. 308 of the Manual, the bad debts of Medicare beneficiaries are allowable when reasonable collection efforts were made. In the present case, the disallowance of Medicare bad debts is not an issue; the provider did not dispute that adjustment. The failure to conduct a reasonable collection for Medicare deductibles and coinsurance is not relevant to the reasonable cost of collection agency fees for other receivables. Therefore, the Board's decision is affirmed.

Decision:

Issue 1 — Reclassification of Clinic Administrative Costs:

The Intermediary properly reclassified clinical personnel costs from the A & G cost center to the clinic cost centers and the adjustments to the statistics on Worksheet B-1 were correct.

Issue 2 — Medicare Bad Debts:

The Intermediary's adjustments are modified. The provider's Medicare bad debts are allowable costs. However, recoveries of prior year Medicare bad debts must be offset against them. In addition, the bad debts for Medicaid and noncovered Medicare services are not allowable costs.

Issue 3 — Collection Agency Fees:

Collection agency fees incurred to collect overdue patient accounts are allowable administrative costs for Medicare reimbursement purposes. The Intermediary's adjustments are reversed.

APPENDIX K — DEPARTMENT OF HEALTH & HUMAN SERVICES MEMORANDUM DATED JUNE 11, 1990

DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care
Financing Administration

Memorandum

Director, Bureau of Program Operations
Director, Bureau of Policy Development

Bad Debt Policy

All Regional Administrators

We have received numerous requests for clarification on an issue regarding the Medicare bad debt policy. The primary areas of concern are: (1) the point in the collection effort at which a provider may claim a Medicare bad debt, and (2) the documentation required to support a claim for a Medicare bad debt.

Provider Reimbursement Manual (PRM) Section 310.2, Presumption of Noncollectibility, provides that, "If after reasonable and customary attempts to collect a bill, the debt remains unpaid more than 120 days from the date the first bill is mailed to the beneficiary, the debt may be deemed uncollectible." Our intent has always been that section 310.2 be read within the context of the bad debt policy provided in sections 308 and 310. That is, until a provider's reasonable collection effort has been completed, including both in-house efforts and the use of a collection agency, a Medicare bad debt

may not be reimbursed as uncollectible. This is in accordance with the fourth criterion in section 308 which provides that an uncollected Medicare account cannot be considered an allowable Medicare bad debt unless sound business judgment established that there is no likelihood of recovery at any time in the future. We have always believed that, clearly, there is a likelihood of recovery for an account sent to a collection agency and that claiming of a Medicare bad debt at the point of sending the account to the agency would be contrary to the bad debt policy in sections 308 and 310.

Therefore, in accordance with our position, when we had been informed of such situations, we had advised regional offices and others that a bad debt could not be claimed while an account is at the collection agency.

However, we have been made aware from a number of sources that many providers have claimed a Medicare bad debt upon sending an account to a collection agency and that intermediaries have permitted an allowable bad debt in that situation. This is because a debt referred to a collection agency can sometimes be considered as pending indefinitely - i.e., for as long as the collection agency retains the claim and does not return it to the provider or actually inform the provider that it is uncollectible. Accordingly, we have reexamined our position on this issue, considering the actual language of section 310.2 and the impact of section 4008(c) of the Omnibus Budget Reconciliation Act (OBRA) of 1987, as amended by section 8402 of the Technical and Miscellaneous Revenue Act of 1988 and section 6023 of OBRA of 1989. We refer to those enactments as "the moratorium" on changes to the bad debts policy. They provide as follows:

Appendix K

Continuation of Bad Debt Recognition for Hospital Services. — In making payment to hospitals under title XVIII of the Social Security Act, the Secretary of Health and Human Services shall not make any change in the policy in effect on August 1, 1987, with respect to payment under title XVIII of the Social Security Act to providers for reasonable costs related to unrecovered costs associated with unpaid deductible and coinsurance amounts incurred under such title (including criteria for what constitutes a reasonable collection effort), including criteria for indigency determination procedures, for record keeping, and for determining whether to refer a claim to an external collection agency. The Secretary may not require a hospital to change its bad debt collection policy if a fiscal intermediary, in accordance with the rules in effect as of August 1, 1987, with respect to criteria for indigency determination procedures, record keeping, and determining whether to refer a claim to an external collection agency has accepted such policy before that date, and the Secretary may not collect from the hospital on the basis of an expectation of a change in the hospital's collection policy.

We believe that an intermediary could reasonably have interpreted the title of section 310.2, Presumption of Noncollectibility, to provide that an uncollectible account could be *presumed* to be a bad debt if the provider has made a reasonable and customary attempt to collect the bill for at least 120 days *even though* the claim has been referred to a collection agency. Such an interpretation is reasonable unless it is apparent that the debt is not a bad debt, for example, because the

beneficiary is currently making payments on account, or has currently promised to pay the debt. As noted above, section 310.2 provides that the debt *may* be deemed uncollectible rather than that the debt "shall" or "must" be deemed uncollectible. On the contrary, "may" connotes the existence of discretion. Thus, even after 120 days, a debt should not be deemed uncollectible when there is reason to believe that in fact it is collectible. However, the mere fact that a debt is referred to a collection agency after the provider's in-house collection effort is completed does not mean that the debt is collectible.

Therefore, where an intermediary, in accordance with the preceding paragraph, applied section 310.2 to permit an allowable Medicare bad debt for an account sent to a collection agency, consistent with the provider's procedures for non-Medicare patients, the moratorium would prohibit the intermediary from applying the policy differently despite HCFA directives to the contrary dated subsequent to August 1, 1987. Accordingly, where an intermediary at HCFA's direction later disallowed Medicare bad debts which it had originally allowed, the intermediary should reverse that disallowance.

Finally, we believe that it is important to emphasize that, generally, the bad debt policy is otherwise unaffected by the above discussion. If a provider's collection effort at a collection agency typically extends beyond 120 days, we do not expect that the provider would now cease all collection efforts beyond that time simply based on our recognition that section 310.2 would permit a presumption of a bad debt after 120 days. The provider's additional collection effort may well result in collection of some of the bad debts despite the earlier *presumption* of uncollectibility Moreover, if a provider refers its non-Medicare accounts but not its Medicare accounts to a

collection agency, the Medicare accounts could not be claimed as a Medicare bad debt even after the passage of 120 days. In the same manner, if a provider refers all uncollected accounts to a collection agency but only records in its books the Medicare accounts as bad debts at the point of referral, the Medicare bad debts cannot be allowed. Also, some providers send an informational statement to the beneficiary which does not require payment and believe that the mailing of such a statement starts the 120 days. The 120-day period does not begin until the hospital has made a serious demand for payment, i.e., until it has sent a bill for an amount owed by the beneficiary.

Another concern expressed about the bad debt policy relates to the documentation required to be maintained by providers to support their claim for Medicare bad debts. In resolving this concern; we considered the impact of the moratorium on the bad debt documentation requirements contained in the FY 1990 audit guidelines, which represent a revision to the audit guidelines in effect as of August 1, 1987. The moratorium prohibits the intermediary from disallowing Medicare bad debts on the basis of those revised audit guidelines if the intermediary otherwise would have allowed the bad debts on the basis of its reasonable interpretation of the documentation requirements in effect on August 1, 1987 (including the previous audit guidelines and PRM section 314). Accordingly, when an intermediary disallowed bad debts on the basis of the documentation requirements in the FY 1990 audit guidelines, the intermediary must reverse that disallowance if it would have accepted the provider's documentation, provided that doing so is consistent with PRM sections 310.B, and 314, and the audit guidelines in effect as of August 1, 1987.

To assure proper implementation of these clarifications, the regional offices must issue the above clarifications, as written,

to all intermediaries no later than 1 week after receipt of this memorandum. Also, inform the intermediaries that they should convey the contents of this memorandum to all their providers.

Barbara Gagel

Kathleen A. Buto

APPENDIX L — PROVIDER REIMBURSEMENT REVIEW BOARD HEARING DECISION DATED JUNE 23, 1995 — *UNIVERSITY HOSPITAL v. BLUE CROSS AND BLUE SHIELD ASSOCIATION*

PROVIDER REIMBURSEMENT REVIEW BOARD HEARING DECISION

ON THE RECORD

95-D43

DATE OF HEARING—
November 16, 1994

Cost Reporting Period Ended -
December 27, 1987

CASE NO. 90-1568

PROVIDER— University Hospital Augusta, Georgia

Provider No. 11-0028

VS

INTERMEDIARY—Blue Cross and Blue Shield Association/ Blue Cross and Blue Shield of Georgia

* * *

ISSUE:

Was the Intermediary's adjustment disallowing Medicare bad debts claimed by the Provider proper?

Appendix L

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

University Hospital (the Provider) is a general, short-term, non-profit teaching hospital located in Augusta, Georgia. On its as-filed Medicare cost report for the fiscal year ending (FYE) December 27, 1987, the Provider included a claim for Medicare bad debts. Blue Cross and Blue Shield of Georgia (the Intermediary) disallowed the Provider's Medicare bad debts claim because the Provider had not used similar efforts to collect its Medicare and non-Medicare bad debts as required by the Provider Reimbursement Manual, HCFA Pub. 15-1 (HCFA Pub. 15-1) § 310. The Provider appealed the Intermediary's adjustment to the Provider Reimbursement Review Board (Board) pursuant to 42 C.F.R. §§ 405.1835-.1841 and has met the jurisdictional requirements of these regulations. The amount of Medicare reimbursement in controversy is approximately $450,000.

The Provider was represented by Thomas William Baker, Esquire, of Knox and Zacks, P.C. The Intermediary was represented by David E. Smyth, Esquire, of Blue Cross and Blue Shield Association.

PROVIDER'S CONTENTIONS:

The Provider contends that its collection practices constitute a reasonable effort to collect the Provider's Medicare accounts pursuant to 42 C.F.R. § 413.80(e)(2). It treated both Medicare and non-Medicare accounts in precisely the same manner during the first 120 days and its collection procedures included billing, subsequent billing, follow-up letters, telephone and personal contacts; and each account was evaluated for collection potential. At the end of the 120 day period, both Medicare and non-

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Medicare uncollected accounts were written off as bad debts. The Provider contends that its collection procedures in the first 120 days constituted a genuine, rather than token, effort to collect all accounts. The Intermediary concedes that the Provider's 120 day collection process was a reasonable collection effort that fulfilled the regulatory requirements governing Medicare bad debt reimbursement.[1]

The Provider presented data showing that, using its present collection methods for Medicare accounts, it collected an average of 85 percent of the amount due over the last ten years. The Provider states that for the same ten year period it was more successful in collecting Medicare accounts than non-Medicare accounts. During the four years preceding the FYE 1986 it was 1 to 5 percent more successful; in FYE 1986 it was 6 percent more successful; and, in subsequent years, it was as much as 9 percent more successful. The Provider argues that its decision not to take further collection action on Medicare accounts after 120 days is justified by the following factors. First, it has very experienced management staff who are intimately familiar with the demographic population served by the Provider and with the psychology and needs of the older segment of the population it serves. Second, it has empirical evidence that it is more successful in collecting Medicare accounts than non-Medicare accounts during the 120 day collection period. And third, it has the assessment of representatives who are in direct contact with Medicare accounts about available assets that may be used to satisfy the obligation should further action be taken.

The Provider's knowledge of its community and its older population as well as empirical evidence led it to conclude that the Medicare eligible population would pay an account rather

1. Provider Exhibits 6 and 7.

than risk a poor credit rating. Older community members are very concerned with their credit ratings and generally will do anything to avoid having them negatively affected.[2] The Provider's analysis of non-Medicare accounts, using the same types of information sources, does not yield a similar universal principal for deciding all non-Medicare accounts; therefore, it is appropriate for non-Medicare claims to be referred for further collection.

The Provider argues that it also was sound business judgment not to take further action to collect Medicare accounts and presents evidence that further collection effort on Medicare accounts is non cost-effective. In 1989, it began to refer medicare accounts to its in-house collection agency. The increased costs incurred to collect Medicare accounts were not offset by the amount of additional medicare funds collected. The following are incurred losses in each of the three years since 1989: $34,820, $884 and $62,552, respectively, for fiscal years, 1989, 1990 and 1991.[3]

The Provider notes that its losses were computed in accordance with Medicare accounting regulations found at 42 C.F.R. §§ 413.5 and 413.9 and HCFA Pub. 15-1 § 2102.1. Further, the Intermediary's analysis of the cost of collection effort using incremental costs without taking into account indirect costs is not consistent with generally accepted accounting principals (GAAP) and the Intermediary admits that the Medicare program requires full cost accounting.[4]

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2. Provider Position Paper at 8.

3. Provider Exhibits 8, 9 and 10.

4. Provider Exhibit 23.

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According to the Provider, the following facts are undisputed and are the only facts relevant to this case.

1. the Provider engaged in a reasonable collection effort in collecting its Medicare accounts that is in full compliance with 12 C.F.R. § 413.80(e)(2);

2. the Provider exercised reasonable judgment in the development and implementation of its collections practices, including the decision not to send Medicare accounts to its in-house collection agency; and,

3. empirical evidence that is available on the face of the Provider's cost reports, and calculated in accordance with both Medicare requirements and GAAP, objectively supports the Provider's initial decision regarding referral of Medicare accounts to its in-house collection agency.

The Provider argues that having complied with all regulatory requirements for a reasonable collection effort, its compliance is being reversed by provisions in HCFA Pub. 15-1 § 310(A) that do not have the force and effect of law. The Medicare regulations set out the following four part test to determine whether Medicare bad debts should be allowed:

1. the debt must be related to covered services and derived from deductible and coinsurance amounts;

2. the provider must be able to establish that reasonable collection efforts were made;

3. the debt was actually uncollectible when claimed as worthless; and,

4. sound business judgment established that there was no likelihood of recovery at any time in the future.

42 C.F.R. §§ 413.80(e)(1),(2),(3), and (4).

The Provider asserts that the only issue in controversy is whether the Provider engaged in reasonable collection efforts as required by 42 C.F.R. § 413.80(e)(2). The Intermediary does not challenge and admits that (1) the debts actually were uncollectible when they were written or charged off by the Provider and (2) sound business judgment established that there was no likelihood of recovery at any tine in the future. The Intermediary's position is based on only one fact: after the Provider engaged in a reasonable collection effort for a period of at least 120 days, the Provider did not turn over Medicare accounts, which the Intermediary admits were worthless and uncollectible at any time in the future, to the in-house collection agency. Based upon the evidence in the record and the admissions of the Intermediary, the Provider argues that the Intermediary's adjustment is arbitrary, capricious and unsupported by evidence.

The Provider contends that the Board should decide in its favor because the Intermediary has admitted that the Provider has engaged in a reasonable collection effort in accordance with 42 C.F.R. § 413.80(e)(2). The Intermediary admitted that all of the Provider's costs associated with Medicare bad debt would have been allowed if the Provider had ceased all its collection efforts after 120 days.[5] This is an admission that the Provider's process of collecting Medicare accounts was in full compliance with the applicable regulations.

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5. Provider Exhibit 7.

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The Provider contends that the Intermediary relied solely on HCFA Pub. 15-1 § 310 which states that a reasonable collection process requires efforts to collect Medicare accounts to be "similar" to efforts to collect non-Medicare accounts. The Provider argues that the Intermediary incorrectly interpreted this provision. The Provider contends that it may send only non-Medicare accounts to a collection agency if it undertakes a reasonable collection effort and has a justifiable reason for treating Medicare accounts differently. The Provider cites *Humana Hospital - Sunrise v. Aetna Life Insurance Company*, PRRB Decision No. 92-D41, July 17, 1992, Medicare and Medicaid Guide (CCH) ¶ 40,415, *rev'd* by the HCFA Administrator, September 11, 1992, Medicare and Medicaid Guide (CCH) ¶ 40,415 (*Humana*) in which the Board found the provider's collection efforts reasonable, even though the provider treated Medicare and non-Medicare claims differently with regard to referral to a collect agency. The Provider acknowledges the Administrator's reversal in *Humana* and notes that the decision has been appealed. The Provider also notes that the Board's subsequent decision in *Bradford County Hospital v. Blue Cross and Blue Shield Association/Blue Cross and Blue Shield of Florida*, PRRB Decision No. 92-D72, September 30, 1992, Medicare and Medicaid Guide (CCH) ¶ 40,842, *aff'd* by the HCFA Administrator, November 24, 1992, Medicare and Medicaid Guide (CCH) ¶ 41,062 (*Bradford*) is consistent with the Administrator's decision in *Humana*.

The Provider asserts that the instant case is distinguishable from both *Humana* and *Bradford*, because it has submitted empirical evidence of its lack of success in collecting Medicare accounts and presented a rational basis for not turning Medicare accounts over to the in-house collection agency. The facts in this case are

similar to those in two earlier Board decisions in which the providers' practice of referring only non-Medicare accounts to collection agencies was found reasonable. *See, Reed City Hospital v. Blue Cross Blue Shield Association/Blue Cross and Blue Shield of Michigan*, PRRB Decision No. 86-D67, February 20, 1986, Medicare and Medicaid Guide (CCH) ¶ 35,474, HCFA Administrator declined review, March 31, 1986 (*Reed*) and *St. Francis Hospital and Medical Center v. Blue Cross and Blue Shield Association/Kansas Hospital Service Association, Inc.*, PRRB Decision No. 86-D21, November 12, 1985, Medicare and Medicaid Guide (CCH) ¶ 35,302, *aff'd* by HCFA Administrator without written opinion, January 8, 1986, Medicare and Medicaid Guide (CCH) ¶ 35,356 (*St. Francis*). In *Reed*, reasonable collection effort was found where the provider's experience collecting bad debts revealed that the results of submitting Medicare accounts to a collection agency would have been negligible due to the highly indigent population in its service area and the provider's subsequent attempt to collect Medicare accounts with a collection agency produced insignificant results. In *St. Francis*, reasonable collection effort was found where the provider had referred its Medicare accounts to the collection agency and these efforts produced negligible results.

According to the Provider, *Reed* and *St. Francis* establish the following "test" to establish a reasonable collection effort.

> A provider complies with the reasonable collections effort required by 42 C.F.R. § 413.80(e), when the provider refers only non-Medicare accounts to an outside collection agency after a genuine in-house collection effort of at least 120 days, *if* the provider

can provide evidence of the initial reason for this policy.[6]

The Provider contends that it satisfies the test because it submitted evidence that the reason for its policy is its historically high collection of Medicare accounts in the first 120 days, its intimate knowledge of the elderly in its community, and its individual contact with Medicare beneficiaries and/or their representatives. The Provider's business judgment not to refer Medicare accounts had been validated by the losses it suffered when referring Medicare accounts to the in-house collection agency since 1989.

The Provider contends that the Intermediary found its economic losses from referring Medicare accounts for further collection irrelevant because this consideration is not explicit in the regulation or manual provisions. However, such an interpretation is incorrect because Medicare providers are guided by the "Prudent Buyer Principal," delineated in HCFA Pub 15-1 § 2103. Additionally, requiring a Provider to suffer a loss in pursuing collection of Medicare accounts is contrary to regulatory requirements that the costs of Medicare patients not be borne by other patients since these costs must come from other patients. *See* 42 C.F.R. § 413.5(a).

The Provider argues that the Intermediary is incorrect in its claim that Medicare has contributed to the support of its in-house collection agency and, therefore, is entitled to have it used to collect Medicare accounts. With the advent of the prospective payment system such cost based reimbursement was eliminated.

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6. Provider Position Paper at 19.

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The Provider notes that the Intermediary questions its claim that it suffered losses in referring its Medicare accounts to its in-house collection agency. The Provider asserts that the data it presented, which show three years of losses on Medicare accounts, was prepared in accordance with GAAP. The Provider argues, contrary to the Intermediary's suggestions, that its analysis should not be based upon an incremental cost analysis. The Provider points out that 42 C.F.R. § 413.5, HCFA Pub. 15-1 § 2021.1 and GAAP, would require the addition of indirect costs incurred in referring Medicare claims to its collection department.

The Provider asserts that there are no objective standards for determining whether a provider has met its obligation to reasonably collect Medicare bad debts. The Provider suggests that the Board adopt a presumptive standard in which, if the Provider collects at least 85 percent of its Medicare accounts, and the percentage of Medicare accounts collected is greater than the collection of non-Medicare accounts, the Provider has engaged in a reasonable collection effort.[7] The Provider asserts that its collection efforts have met the proposed presumptive standard.

The Provider argues that the Intermediary's interpretation of HCFA Pub. 15-1 § 310(A) is incorrect. The Provider presents a different interpretation and indicates why the requirement is not applicable to the Provider. First, the Provider notes that HCFA Pub. 15-1 § 310(A) states that, "[a] provider's collection effort *may* include the use of a collection agency in addition to, or in lieu of subsequent billing, follow-up letters, or telephone and personal contacts." (emphasis added). The Provider asserts

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7. Provider Post Hearing Brief at 27.

that it did not use a collection agency in lieu of subsequent billing, follow-up letters, or telephone contacts. Rather, its in-house collection process had all these features and they constituted a genuine effort to collect.

Second, the Provider notes that HCFA Pub. 15-1 § 310(A) states, "[w]here a collection agency is used, Medicare 'expects' the provider to refer all uncollected patient charges of like amount to the agency without regard to class of patient." (emphasis added). The Provider argues that the word "expects" denotes a guideline rather than a requirement and, more importantly, that sentence only refers to a situation where the provider makes a judgment solely upon the value of the account. Here, the Provider has presented undisputed testimony that it did not make its determination based upon the value of the accounts but instead on an analysis of the assets and collectibility of accounts.

Third, the Provider notes that HCFA Pub. 15-1 § 310(A) states that "[t]he 'like amount' requirement may include uncollected charges above a specified amount." (emphasis added). The Provider notes again that this guideline refers to a value-of-account based process, which it did not use.

Finally, the Provider notes that § 310(A) states that "[t]herefore, if a provider refers to a collection agency uncollected non-Medicare patient charges which in amount are comparable to the individual Medicare deductible and co-insurance amount due the provider from its Medicare patients, Medicare *requires* the provider to also refer its uncollected Medicare deductible and co-insurance amounts to the collection agency." HCFA Pub. 15-1 § 310(A) (emphasis added). The Provider contends that even though the word "requires" is used it is modified by the

word "therefore" meaning it is to be read in the light of the previous sentence which states that a provider "may" include like amounts. Again, the Provider asserts that it did not use the method, referred to in HCFA Pub. 15-1 § 310(A), to determine which cases require additional collection efforts via a collection agency and, therefore, the last sentence is not applicable to the Provider.

The Provider also argues that the Intermediary's disallowance of the Medicare bad debts violates Congress' statutory mandate that intermediaries adhere to the same bad debt reimbursement practices that were in effect on August 1, 1987. The Provider refers to § 4008(c) of the Omnibus Budget Reconciliation Act of 1987, P.L. No. 100-203, 101 Stat. 1303-55, as amended by § 8402 of the Technical and Miscellaneous Revenue Act of 1988, P.L. No. 100-647, 102 Stat. 3798 (Moratorium on Medicare Bad Debts) which states:

> [i]n making payments to hospitals under title XVIII of the Social Security Act, the Secretary of Health and Human Services shall not make any change in the policy in effect on August 1, 1987, with respect to payment under title XVIII of the Social Security Act to providers for reasonable costs related to unrecovered costs associated with unpaid deductible and coinsurance amounts incurred under such title (including criteria for what constitutes a reasonable collection effort), including criteria for indigence determination procedures, for recordkeeping, and for determining whether to refer a claim to an external collection agency.

The Provider argues that Congress clarified this provision in § 6023 of the Omnibus Budget Reconciliation Act of 1989,

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P.L. No. 101-239, 103 Stat. 2167, to make clear that intermediary reimbursement practices in effect in 1987 were to remain in place.

> The Secretary may not require a hospital to change its bad debt collection policy if a fiscal intermediary, in accordance with the rules in effect as of August 1, 1987, with respect to criteria for indigency determination procedures, recordkeeping, and determining whether to refer a claim to an external collection agency, has accepted such policy before that date. . . .

The Provider asserts that it made a reasonable collection effort from 1982 to 1987 and that the Intermediary approved the Provider's collection process. The Provider asserts that its case is distinguishable from *Bradford*, because in *Bradford*, the Provider only relied on the advice of the Intermediary as justification for its collection process and did not provide proof of the basis for its collection policy. The Provider asserts it has provided the necessary proof that it compiled worn 42 C.F.R. § 413.80(e) and the associated HCFA Pub. 15-1 provisions.

INTERMEDIARY'S CONTENTIONS:

The Intermediary contends that the Provider applied an equal collection effort to all accounts during the first part of the collection process but that after a certain point non-Medicare accounts were sent to an in-house collection agency for additional collection effort and no further collection effort was made for Medicare accounts.

The Intermediary notes that 42 C.F.R § 413.80(e) specifies four requirements for bad debts to be reimbursable. The adjustment

was in accordance with 42 C.F.R. § 413.80(e)(2) because the Provider did not make a reasonable collection effort. HCFA Pub. 15-1, § 310 further expands on the meaning of the term "reasonable collection effort."

> To be considered a reasonable collection effort, a provider's effort to collect Medicare deductible and coinsurance amounts must be similar to the effort the provider puts forth to collect comparable amounts from non-Medicare patients. It must involve the issuance of a bill on or shortly after discharge or death of the beneficiary to the party responsible for the patient's personal financial obligations. It also includes other actions such as subsequent billings, collection letters and telephone calls or personal contacts with this party which constitute a genuine, rather than a token, collection effort. The provider's collection effort may include using or threatening to use court action to obtain payment.
>
> A. Collection Agencies. — A provider's collection effort may include the use of a collection agency in addition to or in lieu of subsequent billing, follow-up letters, telephone and personal contacts. *Where a collection agency is used, Medicare expects the provider to refer all uncollected patient charges of like amount to the agency without regard to class of patient.* The "like amount" requirement may include uncollected charges above a specific minimum amount. Therefore, if the provider refers to a collection agency its uncollected non-Medicare patient charges which in amount are comparable to the individual Medicare deductible and coinsurance

> amounts due the provider from its Medicare patients, Medicare requires the provider to also refer its uncollected Medicare deductible and coinsurance amounts to the collection agency. Where a collection agency is used, the agency's practices may include using or threatening to use court action to obtain payment.

HCFA Pub. 15-1 § 310 (emphasis added).

The Intermediary asserts that the Provider used a collection agency but did not "refer all uncollected patient charges of like amount to the agency without regard to class of patient," as required by HCFA Pub. 15-1 § 310(A). The Intermediary disagrees with the Provider's argument that its effort to collect both Medicare and non-Medicare accounts up until referral to the collection agency was a reasonable collection effort as required by the regulation. The Intermediary asserts that the decision to take further action on non-Medicare accounts affects the Provider's compliance with the reasonable effort requirement of the regulation. Moreover, the Intermediary states that this policy disregards the requirements of HCFA Pub. 15-1 S 310(A). The Intermediary cites the Administrator's decision in *Humana*, in support of its position. In *Humana*, the Administrator found that the provider was required to follow the equal collection effort rule in HCFA Pub. 15-1 § 310(A) even though the accounts could have been deemed uncollectible under HCFA Pub. 15-1 § 310.2 due to the passage of a specified time. The Administrator's decision further notes that HCFA Pub. 15-1 § 310(A) is consistent with the objectives and purpose of the regulation and reasonably requires, in cases where a collection agency is used, that providers refer all uncollected patient charges of a like amount to the collection agency without regard to

class of patient. In addition, the decision notes that under HCFA Pub. 15-1 § 310(A), Medicare accounts of comparable amounts cannot be claimed as worthless, if the provider failed to use similar collection efforts for Medicare and non-Medicare accounts. The Intermediary notes similar findings in both the Board and Administrator decisions in *Bradford.*

The Intermediary disagrees for several reasons with the Provider's contention that further collection action on Medicare claims is not required because it would not be cost-effective. First, the Intermediary argues that there is no cost-effectiveness exception to the equal effort rule. Second, the Intermediary notes that the collection agency utilized was in-house. The Intermediary asserts that Medicare has reimbursed the Provider for its collection efforts and it is unfair to limit use of the in-house collection agency to non-Medicare accounts. Finally, the Intermediary asserts that the Provider's cost analysis methodology may not be carefully scrutinized.

CITATION OF LAW, REGULATIONS, AND PROGRAM INSTRUCTIONS:

1. *Statutes*:

   a. Title XVIII of the Social Security Act § 1861(v)(l)(A) — Reasonable Cost
   [42 U.S.C § 1395x(v)(1)(A)]

   b. Administrative Procedure Act, 5 U.S.C. § 553 et. seq.

   c. Omnibus Budget Reconciliation Act of 1987 § 4008(c), P.L. No. 100-203, 101 Stat. 1303-55, as amended by § 8402 of the Technical and Miscellaneous Revenue Act of 1988, P.L. No. 100-647, 102 stat. 3798, and

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§ 6023 of Omnibus Budget Reconciliation Act of 1989, P.L. No. 101-239, 103 stat. 2167.

2. *Regulations — 42 C.F.R.:*

§ 413.5	—	Cost Reimbursement - General
§ 413.9	—	Costs Related to Patient Care
§ 413.80	—	Bad Debts, Charity and Courtesy Allowances
§ 413.24	—	Adequate Cost Data and Cost Finding

3. *Program Instructions — Provider Reimbursement Manual, Part I (HCFA Pub. 15-1):*

§ 310	—	Reasonable Collection Effort
§ 312	—	Indigent and Medically Indigent Patients
§ 2102.1	—	Reasonable Costs
§ 2103	—	Prudent Buyer

4. *HCFA Policy Memorandum, "Bad Debt Policy," June 11, 1990, Medicare and Medicaid Guide (CCH) ¶ 38,623.*

5. *Cases*

   a. *Bradford Count Hospital v. Blue Cross and Blue Shield Association/Blue Cross and Blue Shield of Florida*, PRRB Decision No. 92-D72, September 30, 1992, Medicare

and Medicaid Guide (CCH) ¶ 40,842, *aff'd* by the HCFA Administrator, November 24, 1992, Medicare and Medicaid Guide (CCH) ¶ 41,062.

b. *Harris County Hospital District v. Shalala*, 863 F.Supp. 404 (S.D. Texas, 1994).

c. *Hennepin County Medical Center v. Shalala*, U.S. Dist. Ct., Dist. of Minn., 3rd Division, Civil File No. 3-91-725, March 1, 1993, Medicare & Medicaid Guide (CCH) ¶ 41,948.

d. *Humana Hospital — Sunrise v. Aetna Life Insurance Company*, PRRB Decision No. 92-D41, July 17, 1992, Medicare and Medicaid Guide (CCH) ¶ 40,415, *rev'd* by the HCFA Administrator, September 11, 1992, Medicare and Medicaid Guide (CCH) ¶ 40,854.

e. *Reed City Hospital v. Blue Cross Blue Shield Association/ Blue Cross and Blue Shield of Michigan*, PRRB Decision No. 86-D67, February 20, 1986, Medicare and Medicaid Guide (CCH) ¶ 35,474, HCFA Administrator declined review, March 31, 1986.

f. *St. Francis Hospital and Medical Center v. Blue Cross and Blue Shield Association/Kansas Hospital Service Association, Inc.*, PRRB Decision No. 86-D21, November 12, 1985, Medicare and Medicaid Guide (CCH) ¶ 35,302, *aff'd* by HCFA Administrator without written opinion, January 8, 1986, Medicare and Medicaid Guide (CCH) ¶ 35,356.

g. *University Hospital v. Blue Cross and Blue Shield Association/Blue Cross and Blue Shield of Georgia*,

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PRRB Decision No. 93-D55, July 9, 1993, Medicare and Medicaid Guide (CCH) ¶ 41,586, *rev'd* by the HCFA Administrator, September 8, 1993, Medicare and Medicaid Guide (CCH) ¶ 41,763.

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

The Board, after considering the facts, parties' contentions, documentary evidence presented, testimony elicited at the hearing, makes the following finds of fact and conclusion of law: The issue in this case is whether the Provider made a reasonable effort to collect its Medicare bad debts where the Provider used the same genuine effort to collect all its accounts for 120 days, wrote off, as bad debts, all its accounts uncollected after 120 days, and subsequently sent its non-Medicare accounts to its in-house collection agency. The Board decided this same issue for this Provider for FYE 1986 in *University Hospital v. Blue Cross and Blue Shield Association/Blue Cross and Blue Shield of Georgia*, PRRB Decision No. 93-D55, July 9, 1993, Medicare and Medicaid Guide (CCH) ¶ 41,586, *rev'd* by the HCFA Administrator, September 8, 1993, Medicare and Medicaid Guide (CCH) ¶ 41,763 (*University*). The Board findings in the instant case are the same.

The Board finds that the Intermediary incorrectly disallowed the Medicare bad debts claimed by the Provider for FYE 1987. The principal facts in this case are not in dispute. The Provider claimed Medicare bad debts in the same manner as had been its custom for prior years. The record indicates that the Provider had the same collection procedure for both its Medicare and non-Medicare accounts during the first 120 day period. The collection effort involved billing, follow-up billing, letters, and

telephone or personal contacts. The Provider and Intermediary stipulated that the Provider's collection efforts, in the first 120 day period were a genuine, not token, effort to collect Medicare bad debts. The record contains data on the percentage of Medicare bad debts collected both prior to and subsequent to the your under appeal which substantiate the effectiveness of the Provider's collection efforts.

After the 120 day period, the Provider's practice was to write off all accounts, both Medicare and non-Medicare. For Medicare accounts, this practice complied with the provisions of HCFA Pub. 15-1 § 312. The Intermediary's witness testified that the Provider's collection effort up to 120 days was reasonable and genuine and, had the Provider's collection practice ended after 120 days, the case would never have arisen.[8]

In *Bradford*, the Provider failed to provide any reason for not sending Medicare accounts to the collection agency; and therefore, it failed to establish a reasonable collection effort. In the instant case, the Board finds the Provider was required to and did provide a valid reason for failing to send its unpaid Medicare accounts to the collection agency. That reason was based upon sound business judgment and the Provider presented credible evidence to support this decision. The Board finds that the Provider made a reasonable effort to collect these accounts. In *Reed*, and *St. Francis*, a reasonable collection effort was found in situations where Medicare accounts were not forwarded to a collection agency for further collection. In *Reed*, the Board found the provider's collection efforts reasonable where the Provider did not submit Medicare accounts to a collection agency because the recovery rate would have been negligible,

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8. Provider Exhibit 7.

due to the highly indigent population in the service area, and where subsequent collection efforts produced insignificant results. Likewise, in *St. Francis*, the Board and the Administrator found that the provider's referral of Medicare accounts to a collection agency in previous years with no recoveries from Medicare beneficiaries justified the provider's decision not to continue referring Medicare accounts to a collection agency.

In the instant case, the Provider demonstrated that a number of factors contributed to its decision not to refer Medicare accounts to its in-house collection agency and that its decision was validated by poor recoveries in subsequent years. The Provider's factors include the following:

- a very high percentage of its Medicare deductibles and co-insurance accounts were collected in the first 120 days;

- an experienced staff with knowledge of the elderly community which it serves and that community's concern with its credit rating; and,

- the assessment of the Provider's collection personnel who analyzed Medicare accounts for assets and collectibility.

The Board finds the record supports the reasonableness of the Provider's rationale for not referring Medicare claims for further collection. The Board finds evidence in the record that the Provider had knowledge of the Medicare population in its community and did assess Medicare accounts for assets and collectibility. In addition, the Board finds that the evidence presented by the Provider of three years of losses from its

subsequent efforts to collect Medicare accounts validates of its initial decision not to pursue further Medicare accounts.

The Board finds that the accounting methods used by the Provider to allocate its collection costs were proper and in accordance with Medicare principles. The Provider has properly demonstrated that it had suffered losses in collecting Medicare accounts from 1989 to 1991.

The Board rejects the Intermediary's argument that HCFA Pub. 15-1 § 310 does not contain an exception for cost-effectiveness. The Board finds that it would not be logical to insist that a provider, in order to demonstrate reasonable collection effort, adopt collection practices prescribed in HCFA Pub. 15-1 § 310, when it can demonstrate it costs more to collect a patient's bill than the Provider expects to recover. The Board notes that the regulation contemplates that a provider will exercise "sound business judgment" regarding the likelihood of recovery, before bad debts may be claimed. *See* 42 C.F.R. § 413.80(e)(4).

The Provider has presented a reasonable rationale for its different collection practice for Medicare accounts as well as evidence to support its position. Therefore, the Board finds that the Provider has engaged in a reasonable collection effort as required by 42 C.F.R. § 413.80(e)(2).

The Board notes that two recent court decisions have interpreted the Moratorium on Medicare Bad Debts. *See Hennepin County Medical Center v. Shalala*, U.S. Dist. Ct., Dist. of Minn., 3rd Division, Civil File No. 3-91-725, March 1, 1993, Medicare & Medicaid Guide (CCH) ¶ 41,948 (*Hennepin*) and *Harris County Hospital District v. Shalala*, 863 F.Supp. 404 (S.D. Texas, 1994) (Harris). The Board concurs with the interpretation of

the language of the Moratorium on the Medicare Bad Debts in these decisions. In both cases, the courts ruled that the government could not deny Medicare bad debts, if the Intermediary had previously accepted a provider's bad debt collection policy prior to August 1, 1987. *See Hennepin* at 9 and *Harris* at 409. In *Hennepin*, the intermediary had conducted an audit of the provider's bad debts and issued an NPR for the year at issue allowing a substantial portion of these debts. *Id.* at 2. Nearly 3 years later, the intermediary reopened the provider's cost report and disallowed the previously allowed bad debts. *Id.* at 2. The court found that "the Secretary may not seek to recoup Medicare bad debt reimbursement payments after it had accepted a provider's bad debt policies prior to August 1, 1987." *Id.* at 9.

In *Harris*, the court found that the intermediary was aware of the provider's bad debt policy with regard to indigency determinations for years prior to 1988 and had paid full reimbursement for the provider's claims. *Id.* at 409. The court found that "[t]he dispositive question is whether [the intermediary] in fact made a determination before August 1, 1987, that the district's policy for determining indigent status was acceptable." *Id* at 409.

The Board finds that the facts in the instant case are similar to those in *Harris*. *The Intermediary was aware of the Provider's bad debt practices and had paid the Provider for its bad debt claims for a number of years prior to August 1, 1987.* The Board finds that the Moratorium on Medicare Bad Debts prevents the Intermediary from denying bad debts based upon the practices it had accepted previously. The Board rejects the narrow interpretation of the Moratorium on Medicare Bad Debt expressed in HCFA Policy Memorandum, "Bad Debt Policy," June 11, 1990, Medicare and Medicaid Guide (CCH) ¶ 38,623.

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The Board disagrees with Administrator finding that the record in *University* does not support the Board's holding that the Provider adequately justified its decision not to refer its Medicare accounts to the collection agency and that its "reliance upon the earlier decisions in *Reed* and *St. Francis*, which are factually distinguishable, is misplaced." *Id.* at 10, n. 9. First, the Board notes that its decision in *St. Francis* was affirmed. In addition, the Board continues to find that the record supports the Provider's, decision. *Although the facts in the instant case (and in the FYE 1986 case) may not be identical to those in either Reed or St. Francis, they match on what the Board considers the essential finding in each of those cases.* The Board finds the Provider has clearly demonstrated it has otherwise made a reasonable collection effort and ended that collection effort for Medicare accounts prior to referral to a collection agency because it expected and demonstrated that there will be no or negligible recoveries for Medicare bad debts. Therefore, the collection effort meet the reasonable collection effort required by 42 C.F.R. § 413.80(e). A reasonable collection effort *does not* require a provider to take additional collection effort that would result in recoveries insufficient to cover the additional cost of that collection effort. To the extent that HCFA Pub. 15-1 § 310(A) requires a provider to lose funds referring Medicare account to a collection agency it is not reasonable.

The Board notes that in *University* one Administrator found the Provider's rationale underlying the decision not to send the Medicare account to the in-house collection agency was largely speculative. The Provider's rationale had *three* parts: (1) the historically higher payment rates of Medicare patients within the first 120 days, (2) knowledge of the elderly community which it serves and their extreme concern with their credit rating; *and, (3) the assessment of their collection personnel who had*

analyzed Medicare accounts for assets and collectibility. The Board finds the Provider's rationale to be reasonable and logical. Since more of the Provider's Medicare accounts are collected than non-Medicare accounts, there is less potential for recovery. Furthermore, the remaining claims have been determined to be less collectible after an analysis of assets and collectibility by the Provider's collection personnel. The lower claim recovery rate coupled with the lower value of Medicare bad debts supports a conclusion that further collection effort will not be cost-effective. Moreover, the record contains evidence that the percentage of Medicare claims recovered after 120 days was less for Medicare patients in subsequent years.[9]

The Administrator also expressed concern with using evidence of losses on Medicare bad debt collections using cost data from FYEs 1989 through 1991, when the year in question was FYE 1986, and presumably in this case where the year in question is FYE 1987. *The Board does not find the differences in costs between 1986 and later years to be an important consideration.* The Provider has clearly demonstrated that in FYEs 1989 through 1991 it experienced losses referring Medicare accounts to its in-house collection agency. *The Board, as in Reed, finds that losses from collection efforts in subsequent years validate the Provider's rationale for not referring its Medicare accounts to its in-house collection agency.*

The Board notes that the regulations regarding bad debt collection have not changed since the inception of the program. On the other hand, the HCFA Pub. 15-1 provisions concerning referral of Medicare bad debts to collection agencies have changed. The Board notes that initially § 310 provided that:

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9. Provider Exhibit 5.

Appendix L

> [t]he amount of effort put forth by providers to collect the deductibles and coinsurance amounts of Medicare patients *should* be similar to the efforts customarily put forward to collect bills of comparable amounts of non-Medicare patients.
>
> . . .
>
> The provider need not resort to a collection agency unless it customarily does so for its other patients.

HCFA Pub. 15-1 § 310 (1968) (emphasis added).

Section 310 was modified in 1978 to clarify that when a collection agency was used, the collection fees were only allowable if all uncollected charges of like amounts were referred. It provided that:

> [a] provider's collection effort may include the use of a collection agency in addition to or in lieu of subsequent billing, follow-up letters, telephone, and personal contacts.
>
> If a collection agency is used, the provider need not refer all uncollected patient charges to the agency; it may refer only uncollected charges above a specified minimum amount. Where a collection agency is used, Medicare *expects* the provider to refer all uncollected patient charges of like amount to the agency without regard to class of patient.

HCFA Pub. 15-1 § 310 (1978) (emphasis added).

Appendix L

Section 310 was again modified in 1981 and now provides as follows:

> Where a collection agency is used, Medicare expects the provider to refer all uncollected patient charges of a like amount to the agency without regard to class of patient. The "like amount" requirement may include uncollected charges above a specified minimum amount. Therefore, if a provider refers to a collection agency its uncollected non-Medicare patient charges which in amount are comparable to the individual Medicare deductible and coinsurance amounts due to the provider from its Medicare patients, Medicare *requires* the provider to also refer its uncollected Medicare deductible and coinsurance amounts to the collection agency.

HCFA Pub. 15-1 § 310 (1981) (emphasis added).

The Board notes that the manual provisions are guidelines and are not bindings requirements. The Board finds that HCFA is using the manual to impose new add increasingly restrictive burdens on providers concerning what constitutes a reasonable collection effort. The Board finds that these changes constitute new substantive requirements that must be promulgated in accordance with the Administrative Procedure Act, 5 U.S.C. § 553 et. seq., that is, by regulation with notice and opportunity for comment.

DECISION AND ORDER:

The Intermediary's adjustment disallowing Medicare bad debts was not proper. The Intermediary's adjustment is reversed.

Appendix L

Board Members Participating:

Irvin W. Kues
Michael D. Richards
Charles E. Tyler
Melanie A. Vaughn, Esquire

FOR THE BOARD:

JUN 23 1995

s/ Irvin W. Kues
Irvin W. Kues
Chairman